Research & Demonstrations In Health Care Financing

Active Projects

October 1, 1995

Health Care Financing

Active Projects

The Office of Research and Demonstrations (ORD), Health Care Financing Administration (HCFA), directs more than 400 research, evaluation, and demonstration projects. A central focus is on program expenditures as they relate to payment, coverage, eligibility, and management alternatives under Medicare and Medicaid. Study activity also examines program impact on beneficiary health status, access to services, utilization, and out-of-pocket expenditures. The behavior and economics of health care providers and the overall health care industry also are topics of investigation.

In March 1995, ORD underwent a reorganization and is now comprised of six components—four offices and two staffs. The new functions are briefly described in the following section:

The *Office of State Health Reform Demonstrations* is responsible for managing HCFA's Medicare and Medicaid demonstration waiver authorities, including the Federal review, approval, and oversight of State health reform waivers. The *Office of Payment and Delivery Research and Demonstrations* directs two major sets of activities: the development of more efficient and effective health care delivery systems, which is the focus of the Division of Delivery Systems and Financing; and the development, refinement, and testing of payment methods, which is the focus of the Division of Payment Systems. The *Office of Beneficiary and Program Research and Demonstrations* directs research on the Medicare and Medicaid programs and their beneficiary populations. Its Division of Health Information and Outcomes focuses on issues such as health status and outcomes, service use, access to care, expenditures, and quality care. Its Division of Aging and Disability directs research and demonstrations related to eligibility, coverage, access, and the quality of long-term-care services. The *Office of Research and Demonstrations Support* consists of two components. The Division of Demonstration Support conducts fiscal intermediary and carrier activities for demonstrations and supports the implementation and operations of demonstrations. The Division of Data Systems Resources is responsible for developing and maintaining a variety of data programs to monitor and evaluate trends in health. The *Financial, Administrative, and Procurement Staff* manages ORD's personnel, budget, administrative, and procurement activities. The *Dissemination Staff* manages ORD's dissemination, publications, inquiries activities. This includes producing and distributing the *Health Care Financing Review*, *Active Projects*, and Reports to Congress. Dissemination Staff also serves as ORD's legislative and public affairs liaison.

This report provides basic information on active intramural and extramural projects in a brief format. These projects are used to assess new methods and approaches for providing quality health care while containing costs, and they often provide the basis for making critical policy decisions on health care financing issues. Projects are arranged according to ORD budget priority areas. The synopsis on each project includes an identification number, the title, project number, project period, name of principal investigator, name and address of awardee, contractor, or grantee organization, Federal project officer with primary responsibility for the project, Federal statute, a brief description, and the status of the project as of October 1, 1995. When a project involves research and development funds, the total funding amount for the life of the project is included. Remaining extramural projects are being conducted with waivers that permit innovations to financing and delivery of health services under the Medicare and Medicaid programs. Intramural ORD research studies also are described.

This is the sixteenth edition of the *Active Projects* (formerly, the *Status Report*). Updated editions are produced on an annual basis. The information presented should be of use to policy officials, health planners, and researchers in examining the range of research and demonstration activities that are undertaken by ORD and the implications of results and findings.

In this year's edition, we have broadened the topical keyword index of projects to make the *Active Projects* more useful to our readers in identifying and locating projects. We have also added summaries of selected accomplishments.

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U.S. Department of Health and Human Services
Health Care Financing Administration
Office of Research and Demonstrations
Baltimore, Maryland 21244-1850

HCFA Pub. 03381
June 1996

Acknowledgments

Several people contributed to the successful completion of this report--Gloria Smiddy of the Office of State Health Reform Demonstrations; Sherry A. Terrell, Ph.D., of the Division of Delivery Systems and Financing; William J. Sobaski of the Division of Payment Systems; Nancy A. Miller of the Division of Aging and Disability; and Cheryl Hickman of the Division of Health Information and Outcomes provided extensive support in production management. Naomi Bundy and Doris Hall of the Dissemination Staff provided support in editorial managment and printing management.

Requests to be placed on our mailing list to receive notification of future publications as they become available shoud be sent to: Health Care Financing Administration, Office of Research and Demonstrations, Dissemination Staff, C3-11-07, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

We are available online. Our address is: http://www.HCFA.gov.

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ORD Makes a Difference: A Summary of Selected Accomplishments

As the research arm of the Health Care Financing Administration (HCFA), the Office of Research and Demonstrations (ORD) performs and supports research and demonstration projects to develop and implement new health care payment approaches and financing policies, and to evaluate the impact of HCFA's programs on its beneficiaries, providers, States, and others. The scope of ORD's activities embraces all areas of health care: costs, access, quality, service delivery models, and financing approaches. ORD carries out these responsibilities through both intramural research by its multi-disciplinary staff of economists, physicians, health professionals, social scientists, and health policy analysts, and extramural research sponsored through contracts, grants, interagency agreements, and approvals of Medicare and Medicaid demonstration waivers.

ORD provides leadership and executive direction within HCFA for a wide range of health care financing research and demonstration activities, such as studying vulnerable populations, dealing with alternative health plans, and developing risk adjusters for payments systems. ORD develops, tests, and evaluates new payment methods, coverage policies, and delivery mechanisms in Medicare, Medicaid, and other health care programs.

Over the past three decades, HCFA's Office of Research and Demonstrations (ORD) and its predecessors have had a profound impact on the evolution of the Medicare and Medicaid programs. Through support, development, and testing of innovations in payment, delivery, access and quality, ORD has significantly contributed to major program reforms and improvements. The following list of selected accomplishments outlines just a few of the major contributions of this Office.

PAYMENT

Hospital Payment Reform. With ORD-supported research and demonstrations, Medicare moved from cost reimbursement for hospital care to a prospectively determined per case payment based on diagnosis. ORD's efforts resulted in legislation requiring the use of a DRG system—diagnosis-related groups—as the method of Medicare payment for most hospital care. Implemented in 1983, the DRG system saves billions of Medicare dollars annually and is used today by half of the state Medicaid programs, CHAMPUS, and many insurers, managed care plans, and other countries. It represents the most common form of hospital payment in the U.S. today.

Physician Payment Reform. Through ORD-supported research, a uniform, resource-based fee schedule for paying physicians was developed to replace the Medicare retrospective, charge-based system. This new system was part of physician payment reform legislated in 1989 and implemented in 1992. The concept of using resource-based payment for physician services has spread beyond Medicare to nearly three-quarters of public and private insurers.

Risk Adjustment. Recognizing that risk adjusters are widely needed for payment systems, and monitoring and evaluation purposes, ORD has taken the clear lead in pursuing all viable methods of developing both basic (e.g., based on carve outs for high cost cases) and more complex risk adjusters, such as ambulatory care groups (ACGs) and diagnostic cost groups (DCGs), which use diagnoses from a prior year to predict program costs in a subsequent year. ORD also is exploring the development of other risk adjustment mechanisms, including ACG- and DCG-hybrids, and adjusters for such various populations as the under-65 group and the disabled.

Managed Care Payment Reform. Medicare currently pays HMOs a capitated amount for each enrollee based on average fee-for-service spending in the enrollee's demographic group. ORD's selection studies showed that HMO enrollees tend to be healthier than average, indicating that capitation amounts may be too high. Through ORD-supported research, several methods of adjusting for an enrollee's relative health risk have been developed. These methods of risk-adjusting managed care payment are being tested in ORD demonstrations across the country in the next few years. These include ACGs and DCGs, as well as other risk adjusters based on more clinical data or survey data.

Outpatient Payment Reform. Hospital outpatient departments are currently paid by Medicare on a cost basis. The availability of Ambulatory Patient Groups (APGs), developed by ORD-sponsored research, has made prospective payment methods now possible. HCFA recently submitted a Report to Congress recommending legislation that would permit such payment reform.

Nursing-Home Payment Reform. An innovative payment classification system developed through ORD has the potential for significantly changing payment in various care settings. Resource Utilization Groups (RUGs) classifies patients based on costs according to

the relationship of their various medical, functional, and personal characteristics and their daily use of staff time. RUGs originally were developed for reimbursement of care received by Medicaid residents in nursing homes. More recently, the concept was adapted and refined for paying for Medicare-covered patient care in certified skilled nursing facilities. A six-state ORD demonstration project is underway to pay nursing homes for Medicare and Medicaid patients on a prospective basis tied largely to residents' needs.

Centers of Excellence. ORD has developed and demonstrated negotiated package prices for all services during episodes of high-cost/high volume surgeries (heart bypass and cataract), aimed at reducing spending by the program and its beneficiaries and providing high quality services. As a direct result of successful ORD testing, the centers of excellence approach is part of the President's legislative package.

DELIVERY

HMO Participation. Originally, Medicare was essentially a fee-for-service program, with very limited enrollment in the incentive-payment HMOs authorized under section 1876 of the Social Security Act. Through an extensive demonstration effort, ORD tested the use of capitation for HMOs participating in Medicare. This pioneering effort demonstrated to plans, Congress, and the executive branch that HMO participation in Medicare on a capitated basis was a viable option. Today, about 260 plans participate and 10 percent of Medicare beneficiaries are enrolled.

Program for All-Inclusive Care for the Elderly (PACE) Demonstration. PACE replicates a unique model of managed care service delivery for 300 very frail community-dwelling elderly, most of whom are dually-eligible for Medicare and Medicaid coverage and all of whom are assessed as being eligible for nursing home placement according to the standards established by the participating States. The model of care includes as core services the provision of adult day health care and multidisciplinary team case management through which access to and allocation of all health and long-term care services are arranged. This model is financed through prospective capitation of both Medicare and Medicaid payments to the provider.

Hospice. When the hospice movement was still in its infancy, ORD initiated a Medicare/Medicaid demonstration to determine whether hospice care could maximize patient autonomy during the last weeks of life and allow terminally ill patients to die with as much dignity as possible and relatively free of pain. Largely as a result of this successful demonstration effort, legislation established hospices as authorized Medicare providers. In 1993, about 215,000 Medicare beneficiaries used hospice care.

Swing-Bed. In the 1970s, the shortage of nursing home beds for frail elderly in many rural areas along with excess hospital bed capacity in those areas led ORD to test the swing-bed concept—the use of existing hospital staff and facilities to render both acute and long-term care. The successful demonstrations resulted in legislation that authorized the rural swing-bed program for small rural hospitals.

Home and Community-based Care. Beginning in the mid-1970s, ORD sponsored a series of innovative Medicare and Medicaid demonstrations throughout the country to test the use of community-based services as substitutes for more costly institutional care. These demonstrations served as the framework for the legislation authorizing the Medicaid 1915(b) waiver program in which home and community-based services may be covered services.

ACCESS AND QUALITY

Expanded Eligibility. ORD launched a major demonstration effort to test innovative methods of providing health care to Medicaid beneficiaries. These projects include expanding Medicaid coverage to more people at no additional cost, exploring new delivery systems (often including managed care) to provide access to quality health care, trying new administrative systems, and developing methods for monitoring. Over one dozen approved Statewide Medicaid health reform projects will ultimately provide coverage to about 7 million persons, including about 2.2 million low-income persons not otherwise eligible.

Access Measurement. ORD pioneered methods of measuring access to care for vulnerable populations. Using these methods, ORD has produced numerous studies documenting potential access problems among such vulnerable subgroups as persons with AIDS, the disabled, low-income, and racial minorities. These studies were among the first to document significant racial differences in access to care by Black Medicare beneficiaries and have resulted in a variety of HCFA initiatives to address these differentials.

Improved Care Campaigns. ORD has significantly contributed to the development of usable information on local rates of mammography and influenza immunizations in order to target areas for improvement. HCFA data were a key element in attracting the involvement of the First Lady in the Medicare mammography campaign, with ORD providing technical assistance directly to the First Lady and her staff.

Nursing-Home Quality of Care Measurement. ORD-sponsored research has developed outcome-oriented quality-of-care indicators for nursing homes. The result is an outcome-based quality improvement system and a set of quality-of-care indicators developed using resident-level assessment information.

Health Care Systems Reform and Financing

Extramural

92-022 Actuarial Methods for Improving Health Care Financing Administration Payment to Risk Health Maintenance Organizations

Project No.:	17-C-90033/3
Period:	February 1992–November 1995
Funding:	$ 449,510
Award:	Cooperative Agreement
Principal Investigator:	Charles William Wrightson
Awardee:	Actuarial Research Corporation 6928 Little River Turnpike, Suite E Annandale, VA 22003
HCFA Project Officer:	Cynthia Tudor, Ph.D. Division of Delivery Systems and Financing

Description: This project will assess four alternatives to the adjusted average per capita cost method for paying Medicare health maintenance organizations. They are as follows:

- Partial capitation: Some services are paid on a prospective capitation basis, and others are paid retrospectively on a cost basis.
- Reinsurance with Medicare as the reinsurer.
- Prospective experience rating in which a prospective payment will be made on the basis of past experience.
- Select and ultimate rates: This method takes into account initial favorable selection with an adjustment for regression to the mean over time.

Status: Analysis is under way. Tabulations have been provided that show the required reductions in the adjusted average per capita cost for providing reinsurance at specified threshold levels. The impact of different plan coinsurance levels is also included in the tables. The final report has been received and is currently under review.

94-107 Alternative Health Risk Adjusters for the Medicare Risk Program

Project No.:	17-C-90366/3
Period:	September 1994–September 1996
Funding:	$ 501,581
Principal Investigator:	Sheldon Retchin, M.D.
Awardee:	Virginia Commonwealth University P.O. Box 980568 Richmond, VA 23298-0568
HCFA Project Officer:	Cynthia Tudor, Ph.D. Division of Delivery Systems and Financing

Description: The goal of this project is to develop an implementable risk adjuster that is based on a history of cancer, heart disease or stroke, and severity of illness; the length of time since the last hospital stay; and comorbidities. The predictive power from using history of serious illness will be compared to the predictive power of two existing risk adjusters—the diagnostic cost group and ambulatory care group models. Both predictive accuracy and operational features will be compared. The study is intended to yield information on the extent to which the health risk adjusters are likely to eliminate over- or underpayment in the Medicare risk program under various assumptions about biased selection in health maintenance organizations. The ultimate objective is to revise the risk adjustment procedures used in the Medicare risk program.

Status: Two changes have been made to the methodology. First, the study will use outpatient hospital and physician records, rather than only inpatient records, to identify patients with serious conditions. Second, a risk adjustor will be developed that will pay plans retrospectively for a high-cost illness and that will also determine the payment during the current year for those patients. Other preliminary findings from the study are expected in early 1996.

94-072 Analysis of the Validity of the Discretionary Component of Diagnostic Cost Group Risk Adjusters

Project No.:	17-C-90295/1
Period:	September 1994–February 1996
Funding:	$ 97,341
Award:	Cooperative Agreement
Principal Investigator:	Frank W. Porell, Ph.D.
Awardee:	DataChron Health Systems, Inc. 763 Massachusetts Avenue, Suite 7 Cambridge, MA 02139
HCFA Project Officer:	Michael Kendix, Ph.D. Division of Health Information and Outcomes

Description: The study investigates the validity of the discretionary component of the diagnostic cost group (DCG) risk classification system and three other methods for distinguishing discretionary and nondiscretionary diagnoses. This entails an assessment of the extent to which the differences among health maintenance organizations, fee-for-service providers, and geographic variations in hospital admissions rates can be associated with variations in rates of discretionary hospital admissions. In addition, this study examines the relationship between the aggregate rate of nondiscretionary admissions and mortality rates. The empirical performance of the DCG discretionary ratings, in this regard, is compared with the performance of several alternative classifications of discretionary admissions.

Status: The project's progress has been delayed due to difficulty obtaining data; as a result, a 6-month, no-cost extension has been granted.

82-001 **Arizona Health Care Cost-Containment System**

Project No.:	11-W-00032/9-12
Period:	June 1982–September 1997
Funding:	Waiver only
Award:	Waiver-only Project
Principal Investigator:	Mabel Chen, M.D.
Awardee:	Arizona Health Care Cost-Containment System (AHCCCS) 801 East Jefferson Phoenix, AZ 85034
HCFA Project Officer:	Joan Peterson Office of State Health Reform Demonstrations

Description: This project is designed to test the effectiveness of establishing, under Title XIX of the Social Security Act, a Medicaid program based on competitive principles, including primary care physicians acting as gatekeepers, prepaid capitated contracts, competitive bidding, use of nominal copayments, and limited restrictions on freedom of choice. Acute-care services are provided by health plans and long-term care (LTC) services are provided through capitated contracts by the State with five Arizona counties and two LTC contractors. In addition, capitated behavioral health services are provided to acute-care and long-term care enrollees.

Status: The Arizona Health Care Cost Containment System (AHCCCS) began operation on October 1, 1982, and initially covered only acute care services. The Arizona Long-Term Care System (ALTCS) component was approved as part of a 5-year extension of the AHCCCS demonstration from October 1, 1988, through September 30, 1993. The phase-in of comprehensive behavioral health services began on October 1, 1990, and will be completed on October 1, 1995. On January 6, 1993, the Health Care Financing Administration (HCFA) granted a 1-year extension to the demonstration. On August 16, 1994, HCFA approved an additional 3-year extension of the waivers through September 30, 1997.

94-092 **Assessing the Compatibility of an All-Payer Ratesetting System and Managed Competition: The Maryland Experience**

Project No.:	18-C-90372/1
Period:	September 1994–September 1995
Funding:	$ 153,763
Award:	Cooperative Agreement
Principal Investigator:	Stanley Wallack, Ph.D.
Awardee:	Brandeis University Heller Graduate School Institute for Health Policy 415 South Street P.O. Box 9110 Waltham, MA 02254-9110
HCFA Project Officer:	Brigid Goody, Sc.D. Division of Delivery Systems and Financing

Description: The purpose of this project is to analyze the effect of two features of the Maryland all-payer system on hospital costs and utilization rates of health maintenance organizations (HMOs) from 1986 to 1992. First, rates are set for individual services, and reimbursement is provided for services actually rendered. Second, different rates are set for different hospitals. The proposal will examine the hypothesis that Maryland HMOs lower expenditures by limiting services and choosing less expensive hospitals.

Status: A draft final report is currently under review. The report analyzes the difference between HMO and non-HMO hospital cost per discharge and average length of stay (ALOS). Principal findings include the following:

- Unadjusted difference between HMO and non-HMO cost per discharge and ALOS is 25 percent.
- Less severe HMO admissions as measured by diagnosis-related groups account for 60 percent of the HMO savings in cost per discharge.
- HMO case-mix adjusted-ALOS is 13 percent shorter than non-HMO ALOS.
- Additional HMO savings resulted from their choice of hospitals.

93-040 **Assessing the Viability of Developing All-Payer Systems for Health Care Services: The Urban Institute**

(Formerly, Assessing the Viability of All-Payer Systems for Health Care Services: The Urban Institute)

Project No.:	500-92-0024DO04
Period:	May 1993–March 1996
Funding:	$ 1,325,480
Award:	Delivery Order in Master Contract
Principal Investigator:	John Holahan, Ph.D.
Awardee:	The Urban Institute
	(See page 208)
HCFA Project Officer:	Jesse M. Levy, Ph.D. Division of Payment Systems

Description: The purposes of this delivery order are to assess the viability of constructing an all-payer system for health care services for providers, focusing on hospitals and physicians, and to determine whether such a system would be feasible and desirable. This delivery order will examine a number of practical data-driven issues that must be resolved in creating an all-payer system. The goals for this research include the following:

- Obtaining and analyzing data to be used in the construction of conversion factors, weights, costs per discharge, case-mix indices, and other statistics necessary for constructing all-payer hospital and physician systems.
- Determining what data and other resources would be necessary and are available to create and implement such systems.
- Obtaining and analyzing such data.
- Assessing the distributional implications of all-payer systems.

Status: Work on this project is in progress.

94-091 **Business Health Care Purchasing Coalitions**

Project No.:	18-C-90329/9
Period:	September 1994–March 1996
Funding:	$ 198,667
Award:	Cooperative Agreement
Principal Investigator:	Peter Jacobson
Awardee:	The RAND Corporation 1700 Main Street P.O. Box 2138 Santa Monica, CA 90407-2138
HCFA Project Officer:	Brigid Goody, Sc.D. Division of Delivery Systems and Financing

Description: The purpose of this project is to assess the success of business health care purchasing alliances in reducing health care costs and in expanding access to previously uninsured employees. The project consists of two phases. The first phase of the project will develop case studies of six business coalitions and two State-sponsored health insurance purchasing cooperatives. The second phase of the project will consist of a quantitative analysis of the rates of growth in expenditures or premiums of alliance members relative to regional and national rates of growth.

Status: Five of the six site visits have been completed. A draft report on these case studies is expected during December 1995. Data for the quantitative analysis are currently being collected.

93-008 **Coordinating Health Care Reform with the U.S. Territories and Possessions: Case of Puerto Rico**

Project No.:	18-C-90240/2
Period:	January 1993–January 1995
Funding:	$ 290,482
Award:	Cooperative Agreement
Principal Investigator:	Enrique Baquero
Awardee:	Instituto de Administración y Politica de Salud de Puerto Rico P.O. Box 193745 Hato Rey, PR 00919-3745
HCFA Project Officer:	Gerald F. Riley Division of Health Information and Outcomes

Description: The study will compare the structural organization of the health care system in Puerto Rico to that of a selected sample of States. The investigators want to evaluate health care policies in the sampled States and to determine their possible relevance for Puerto Rico. The project will develop alternative proposals for reform of the health care system in Puerto Rico. Objectives are the following:

- Explain levels of expenditures and growth, access, utilization, payment, and insurance markets in Puerto Rico.
- Identify initiatives in other States and how they may be transferred to Puerto Rico, given the similarities in the health systems.
- Explore initiatives to increase private insurance for small group markets.
- Explore ways to increase Medicare Part B participation.
- Study ways to adapt to national health care reform initiatives.

Some data gathering and analysis will be undertaken. Comparative and descriptive data will be collected on the health status of the Puerto Rican population, its health care system, and the history and unique causes of cost escalation. The project is expected to lay the groundwork for future decisions by defining the issues and problems for which solutions will be needed.

Status: The final report was received in August 1995. The report, "Coordinating Health Care Reform with the U.S. Territories and Possessions: The Case of Puerto Rico," accession number PB96-109806, is available from the National Technical Information Service.

94-001 Developing Methodologies for Assessing the Effectiveness of Medicare Parts A and B Medical Review

Project No.:	500-92-0021DO03
Period:	October 1993–May 1995
Funding:	$ 339,926
Award:	Delivery Order in Master Contract
Principal Investigator:	Allen Dobson, Ph.D.
Awardee:	Lewin/VHI, Inc. (with The Johns Hopkins University) (See page 207)
HCFA Project Officer:	Kevin Young Bureau of Program Operations Division of Utilization Analysis

Description: In the administration of the Medicare program, the Health Care Financing Administration (HCFA) is charged by Congress with the task of developing programs and procedures to identify potentially inappropriate medical utilization and with developing safeguards to ensure that Medicare beneficiaries are not provided with medically unnecessary or inappropriate care. HCFA must provide to Congress and the Office of Management and Budget estimates of a contractor's medical review effectiveness in saving Medicare program dollars. The existing method of assessing the effectiveness of medical review requires new methodologies to quantify the effect of specific medical review activities and to measure the potential offsets to savings. The study has three components:

- Develop new methodologies that would comprehensively assess the effectiveness of existing Medicare intermediary and carrier medical review activities on the Medicare program including offsets to savings.
- Pilot test the newly developed methodologies and modify these methodologies.
- Report on findings from the pilot test and recommend the most reliable and cost-effective methodologies for HCFA implementation.

Recommendations to the awardee on each component were made by HCFA and a technical advisory panel.

Status: This project has been completed, and the final report has been submitted to HCFA.

93-046 Development and Testing of Risk Adjusters Using Medicare Inpatient and Ambulatory Data (Formerly, Development of Risk-Adjustment Models)

Project No.:	500-92-0021DO02
Period:	June 1993–December 1995
Funding:	$ 499,911
Award:	Delivery Order in Master Contract
Principal Investigator:	Jonathan P. Weiner
Awardee:	Lewin/VHI, Inc. (See page 207)
HCFA Project Officer:	Melvin J. Ingber Division of Delivery Systems and Financing

Description: This project continues the development of a patient-classification scheme to help determine capitated rates for Medicare health maintenance organization enrollees based on the expected medical costs of enrollees. The system can be used for risk assessment of enrollees in health plans and for risk adjustment of payments to the plans.

The system, a revision of ambulatory care groups, uses *International Classification of Diseases, 9th Revision, Clinical Modification* codes for diagnoses to develop classes of diseases, each class having similar cost implications for the year following the 12-month data collection period. The disease classes, along with other variables, are entered into a regression model that estimates the future cost implications of a person being coded into each of the classes. In this modeling, diagnoses from inpatient as well as ambulatory records are used. Depending on the particular model, hospitalization or presence of a "hospitalizable condition" is accounted for among the variables.

Status: The project is in its final stages. A final report is expected by the end of 1995.

94-101 Development of a Risk Adjustment System Under Health Reform: Lewin/VHI, Inc.

Project No.:	500-92-0021/05
Period:	July 1994–December 1997
Funding:	$1,028,822
Award:	Delivery Order in a Master Contract

Principal Investigator: Allen Dobson, Ph.D.
Awardee: Lewin-VHI, Inc.
(See page 207)
HCFA Project Officer: Yen-Pin Chiang, Ph.D.
Division of Delivery Systems and Financing

Description: Under this project, two previously developed risk adjustment systems will be modified and combined. Payment amounts for capitated systems were originally developed for the Medicare population and are based primarily on diagnoses associated with inpatient hospital stays. Ambulatory care groups were developed from data for the population under 65 years of age and are based on diagnoses found in outpatient claims for physician services. These risk adjustment systems will be combined and calibrated on a data set representing several types of insurers: a large health maintenance organization; Federal employees' health benefit (FEHB) program data from Blue Cross/Blue Shield; and Medicaid data from the State of Washington. The project also will develop risk adjusters based on demographic information and will incorporate reinsurance and flat payments for high-cost episodes in its risk adjustment system.

Status: The first phase of the project has been focused on the analyses of alternative schemes of reinsurance and high-cost carve-out based on the FEHB and Washington State Medicaid data. The contractor is expected to deliver a report on its analysis of reinsurance arrangements by December 1995. The development of risk adjustors that incorporate reinsurance arrangements will not be implemented until the second phase of the project.

94-016 Development of a Risk Adjustment System under Health Reform: The Rand Corporation

Project No.: 500-92-0023DO09
Period: July 1994–June 1996
Funding: $ 733,133
Award: Delivery Order in Master Contract
Principal Investigator: Grace M. Carter, Ph.D.
Awardee: The RAND Corporation
(See page 208)
HCFA Project Officer: Melvin J. Ingber
Division of Delivery Systems and Financing

Description: This project will develop a risk assessment and risk adjustment system for the non-Medicare population. It proposes to combine a diagnosis-based system for grouping episodes of illness to determine a basic capitation level, prospective payment for particular episodes, and reinsurance as a risk-reducing system. A modified diagnosis group severity system will be the basis for defining types of episodes. The system could be used to assess the expected costs of health plan enrollees and to adjust payments to the plans. A theoretical model of provider behavior is to be developed as a guide to structuring a risk adjustment and reinsurance scheme.

Status: Clinical modeling has been done, and the data have been cleaned for analysis.

94-117 Development of Global Risk Assessment Models

Project No.: 17-C-90433/9
Period: September 1994–September 1995
Funding: $ 505,694
Award: Cooperative Agreement
Principal Investigator: Mark Hornbrook
Awardee: Kaiser Foundation Research Institute
1800 Harrison Street
Oakland, CA 94612
HCFA Project Officer: Melvin J. Ingber
Division of Delivery Systems and Financing

Description: The goal of this project is to develop an implementable risk adjuster covering all age groups. It will be based on data from health maintenance organizations (HMOs), such as Kaiser Northwest, Kaiser Ohio, Health Partners, and Group Health Cooperative of Puget Sound. Starting from classifications such as ambulatory care groups, ambulatory diagnosis groups, diagnostic cost groups, chronic disease scores and clinical-behavioral diagnosis groups, a new system will be developed based on diagnoses and demographics. A version of the system using drug prescriptions is also to be developed and related to the diagnosis-driven models. The classification would reflect HMO practices and could be used to assess the expected costs of individuals or groups with respect to each other.

Status: This project is in the final stages.

95-051 Diamond State Health Plan

Project No.: 11-W-00063/3
Period: November 1996–January 2001
Funding: Waiver only
Award: Waiver-only Project
Principal Investigator: Kay Holmes
Awardee: Delaware Health and Social Services
1901 North DuPont Highway
New Castle, DE 19720
HCFA Project Officer: Alisa Adamo
Office of State Health Care Reform Demonstrations

Description: The Diamond State Health Plan (DSHP) will implement a mandatory Medicaid managed-care program statewide. Using savings achieved under managed care, Delaware will expand Medicaid health coverage to approximately 8,000 additional poor adults and children in the State. Through the DSHP, the State seeks to: (1) improve and expand access to health care to more adults and children throughout the State; (2) create a managed-care delivery system emphasizing primary care; and (3) control the growth of health care expenditures for the Medicaid population.

All Medicaid recipients will be eligible for the program, with the exception of those receiving long-term care in institutional or home and community-based settings and those who are eligible for Medicare. Medicaid eligibles not eligible for DSHP will remain in the State's fee-for-service Medicaid. Adults and children with incomes of up to 100 percent of the Federal poverty level will also be eligible for health coverage through the DSHP.

Delaware has contracted with health benefits managers (HBMs) to facilitate and monitor member enrollment in managed-care plans. HBMs will be responsible for outreach and education of potential eligibles through marketing and promotional activities. Delaware is contracting with four managed-care organizations, and everyone eligible for the program will have a choice of at least two plans.

Status: The program is expected to be implemented on January 1, 1996.

94-100 Enrollment and Utilization Across Medicare Supplemental Plans

Project No.:	17-C-90328/1
Period:	September 1994–May 1996
Funding:	$ 207,276
Award:	Cooperative Agreement
Principal Investigator:	Rezaul Khandker, Ph.D.
Awardee:	Center for Health Economics Research 300 Fifth Avenue, 6th Floor Waltham, MA 02154
HCFA Project Officer:	Brigid Goody, Sc.D Division of Delivery Systems and Financing

Description: This study investigates variations in enrollment and utilization across Medicare supplemental plans to identify patterns and determinants of enrollment in supplemental insurance policies and describe the effects of these policies on the utilization of health care services by beneficiaries with differing characteristics and health status. There are three study questions: What factors account for beneficiary choice among the available options? How does utilization vary among those with and without supplemental policies and those with supplemental policies of different types? How does supplemental insurance affect beneficiaries' satisfaction with their health insurance coverage? The study uses data from the Medicare Current Beneficiary Survey (1991-93), Medicare Part A and B records merged with survey respondents, and the area resource file.

Status: Analytical files have been built and data analysis has started.

95-006 Evaluation of HMO Outlier Demonstration

Project No.:	500-95-0047TO02
Period:	September 1995–September 1998
Funding:	$ 449,297
Award:	Technical Support: Evaluation of Demonstrations
Principal Investigator:	Lyle Nelson, Ph.D.
Awardee:	Mathematica Policy Research, Inc. (See page 212)
HCFA Project Officer:	Ronald W. Lambert Division of Delivery Systems and Financing

Description: The awardee will evaluate the Outlier Pool Demonstration. Under this demonstration, participating plans in the Seattle area will be paid at a rate of 97 percent of the adjusted average per capita cost, with 2 percent of the payments going into a pool. Plans with a higher than average incidence of high-cost cases will receive more from the pool than they paid in, and those with a lower incidence will receive less. In this evaluation, the awardee will focus on two primary tasks:

- Examine issues involved in setting up and running an outlier pool.
- Describe the distribution of costs, both of the individuals with claims exceeding the outlier threshold and the population of the plans' enrollees.

The awardee will also be responsible for taking the encounter data submitted by the plans and constructing a person-specific database. This database will be used to address the analytical issues under the second task above.

Status: This contract was awarded on September 30, 1995.

89-033 Evaluation of the Arizona Health Care Cost Containment System

Project No.:	500-89-0067
Period:	September 1989–December 1995
Funding:	$ 3,856,934

Award:	Contract
Principal Investigator:	Nelda McCall
Awardee:	Laguna Research Associates 455 Market Street, Suite 1190 San Francisco, CA 94105
HCFA Project Officer:	Joan Peterson, Ph.D. Office of State Health Reform Demonstrations

Description: The awardee is evaluating the continuing operation of the Arizona Health Care Cost Containment System (AHCCCS), including the Arizona Long-Term Care System (ALTCS). AHCCCS operates a statewide Medicaid managed care program for Aid to Families with Dependent Children and Supplemental Security Income eligibles. Major research questions to be investigated include:

- What is the overall utilization of medical services under the program? How does it compare to other programs?
- Is there evidence of quality issues in the ALTCS or of selection bias in the acute care program?
- What does the AHCCCS program cost and how does that compare to what a traditional Medicaid program would have cost in Arizona?

Status: This evaluation is in its sixth and final year. Four implementation and operation reports and three outcome reports have been completed. The fourth outcome report is still in draft. The draft final report will be submitted in October 1995. According to these reports, ALTCS's use of HCB services appears to be cost-effective for both the elderly and physically disabled and the mentally retarded/developmentally disabled populations. The Prepaid Medicaid Management Information System (PMMIS) development effort has been completed. PMMIS development and operational costs were considerably greater than originally anticipated, and many of the expected financial benefits have not been realized. However, many significant intangible benefits have been experienced, including the ready access to critical program information. The results of the quality of care analysis indicate that ALTCS nursing home residents are more likely to experience a decubitus ulcer, a fever, or a catheter insertion than nursing home residents covered by New Mexico Medicaid. The cost of the AHCCCS program during its first 11 fiscal years (FY 83 to FY 93) averaged 11.2 percent less than the cost of a traditional program in Arizona for medical costs only. When administrative costs are factored in, AHCCCS still cost 6.9 percent less, on average, during the same period when compared to a traditional Medicaid program. The ALTCS program also cost less than a traditional Medicaid program. Total costs (medical and administrative) of ALTCS were estimated to be 7 percent less in FY 89, 8 percent less in FY 90, 15 percent less in FY 91, 22 percent less in FY 92, and 21 percent less in FY 93.

95-028 Evaluation of the Demonstration Entitled Delaware Health Care Partnership for Children

Project No.:	500-92-0033
Period:	October 1994–September 1997
Funding:	$ 498,035
Award:	Delivery Order in Master Contract
Principal Investigator:	James Lubalin
Awardee:	Research Triangle Institute (See page 202)
HCFA Project Officer:	David W. Walsh Office of State Health Reform Demonstrations

Description: The purpose of this contract is to evaluate the Delaware Health Care Partnership for Children. This evaluation will be conducted by Research Triangle Institute (RTI) and its subcontractor, Health Economics Research, Inc. (HERI). RTI/HERI will evaluate the effectiveness of the demonstration to reach its goal of improving access to and the quality of health care services delivered to Medicaid-eligible children in a cost-effective way. The State believes that by enrolling children into a managed-care system operated by the Nemours Foundation, they will reap the benefits of a higher level of coordinated care, while the State, and in turn the Federal Government, will benefit from lower Medicaid costs.

Status: The evaluation contract was awarded in October 1995. RTI/HERI are in the second year of the evaluation.

94-127 Evaluation of the Oregon Medicaid Demonstration

Project No.:	500-94-0056
Period:	October 1994–September 1999
Funding:	$ 4,433,954
Award:	Contract
Principal Investigator:	Margo L. Rosenbach, Ph.D.
Awardee:	Health Economics Research, Inc. 300 Fifth Avenue, 6th Floor Waltham, MA 02154
HCFA Project Officer:	Paul J. Boben, Ph.D. Office of State Health Reform Demonstrations

Description: The objectives of the Oregon Medicaid Reform Demonstration are to increase the number of individuals with access to affordable health care services and to contain State and Federal expenditures for health care. Under the demonstration, Medicaid coverage is made available to all State residents with family incomes less than or equal to the Federal poverty level (FPL). Two distinct strategies are used

to generate the program savings needed to support the expanded enrollee population. The Medicaid benefit package is restructured by establishing a prioritized list of conditions and related treatments (CT pairs), limiting coverage to a preestablished number of CT pairs, and expanding the use of managed care for the delivery of Medicaid services. The demonstration began operation on February 1, 1994, and is scheduled to run for 5 years. The objectives of the evaluation are to determine the impact of the demonstration on access to care, quality of care, enrollee satisfaction, and the cost of care, for both new enrollees and those previously enrolled in Medicaid. To the extent possible, the impact of the prioritized list and the increased use of managed care will be identified separately. Other areas of interest include the impact of the demonstration on the number of uninsured in the State, provider participation and satisfaction, and the number of private employers who offer health insurance as a fringe benefit. The evaluation also will assess whether the concepts being tested in Oregon can be used in other States.

As initially conceived, the scope of the evaluation was restricted to Phase I of the demonstration, in which only Aid to Families with Dependent Children (AFDC) and AFDC-related Medicaid recipients, as well as individuals with incomes under 100 percent of the FPL made eligible by the demonstration, would participate. In September 1995, the contract was modified to provide for additional analyses focusing on the experience of the aged, blind, and disabled Medicaid recipients who enrolled in managed-care plans under Phase II of the demonstration. The new analyses will be similar to those described above for the Phase I evaluation. In addition to Medicaid claims and encounter data, the evaluator will make use of disability data furnished by the Social Security Administration, as well as disability-related databases maintained by the State. The portion of the evaluation focusing on disabled recipients is sponsored jointly by Health Care Financing Administration/Office of Research and Demonstrations and the Office of the Assistant Secretary for Planning and Evaluation.

Status: Site visits to Oregon were held in November 1994 and October 1995. The baseline survey of new Phase I Oregon Health Plan enrollees was submitted to Office of Management and Budget for clearance. Drafts of the other Phase I surveys are nearly complete. Some baseline claims data have been collected for analysis. Work on the Phase II analysis is just beginning.

94-126 **Evaluation of the State Medicaid Reform Demonstrations**

Project No.:	500-94-0047
Period:	September 1994—September 1999
Funding:	$ 5,636,584
Award:	Contract
Principal Investigator:	Judith Wooldridge
Awardee:	Mathematica Policy Research, Inc. 600 Maryland Avenue, SW., Suite 550 Washington, DC 20024-2512
HCFA Project Officer:	James P. Hadley Office of State Health Reform and Demonstrations

Description: Mathematica was awarded this contract to evaluate five State Medicaid reform demonstrations: Hawaii's Health QUEST, Rhode Island's RIteCare, and Tennessee's TennCare, with two other states that were to be added as their waivers are approved.

The evaluator is conducting State-specific and cross-State analyses of demonstration impacts on utilization, insurance coverage, public and private expenditures, quality, access, and satisfaction. Analyses of all groups will, where possible, be stratified by age, income, geographic location, and other relevant demographic variables. Data will come from site visit interviews with providers, advocacy groups, and State officials; participant surveys; State Medicaid Management Information Systems and encounter data; hospital discharge data; routine cost reports from the State and providers; vital records; and secondary data sources such as the area resource file and current population survey.

Status: During the first year of the evaluation, the contractor worked to refine the evaluation design; conducted site visits to Hawaii, Tennessee, and Rhode Island; and began an examination of the quality of encounter data being collected by these States. At the end of fiscal year 1995, Oklahoma and Vermont were named as the two additional States to be included in the evaluation. The first annual report is expected December 31, 1995, with subsequent annual reports expected in 1996, 1997, and 1998. The final report is due September 30, 1999.

95-052 **Evaluation of the State Medicaid Reform Demonstrations**

Project No.:	500-95-0040
Period:	September 1995–September 2000
Funding:	$ 5,959,408
Award:	Contract
Principal Investigator:	Stephen Zuckerman, Ph.D.
Awardee:	The Urban Institute 2100 M Street, NW. Washington, DC 20037
HCFA Project Officer:	Edward T. Hutton, Ph.D. Office of State Health Reform Demonstrations

Description: This contract will evaluate five State Medicaid reform demonstrations: Ohio's OhioCare, Minnesota's MinnesotaCare, and three additional States. The three additional States will be determined by consideration of the timing of the demonstration's implementation.

The evaluator will conduct State-specific and cross-state analyses of demonstration impacts on use, insurance coverage, public and private expenditures, quality, access, and satisfaction. Analyses of all groups will, where possible, be stratified by age, income, geographic location, and other relevant demographic variables. Data will come from site visit interviews with providers, advocacy groups, and State officials; participant surveys; State Medicaid Management Information Systems and encounter data; hospital discharge data; routine cost reports from the State and providers; vital records; and secondary data sources, such as the area resource file and Current Population Survey.

Status: The contract was awarded at the end of September 1995. The first annual report is expected January 31, 1997, with subsequent annual reports expected in 1997, 1998, and 1999. The final report is due September 30, 2000.

94-106 **Evaluating Alternative Risk Adjusters for Medicare**

Project No.:	17-C-90316/1
Period:	September 1994–September 1996
Funding:	$ 327,560
Award:	Cooperative Agreement
Principal Investigator:	Gregory C. Pope, Ph.D.
Awardee:	Center for Health Economics Research 300 Fifth Avenue, 6th Floor Waltham, MA 02154
HCFA Project Officer:	Sherry A. Terrell, Ph.D. Division of Delivery Systems and Financing

Description: This project will use a variety of health status measures (e.g., functional limitations, chronic conditions, perceived health status) from the Medicare Current Beneficiary Survey (MCBS), along with the traditional adjusted average per capita cost factors to predict future expenditures for the purpose of risk adjustment. Alternative risk adjusters also will be evaluated. That is, the predictive accuracy of survey-based risk adjusters from the MCBS will be compared to claims-based risk adjusters that have been developed (e.g., diagnostic cost groups, ambulatory care groups, payment amount for capitated systems). This project also will examine the stability of health status risk adjusters over time.

Status: The project team began database construction and variable construction and have produced some limited regression analyses, which indicate that chronic conditions are the single most powerful set of risk factors that explain total 1992 Medicare reimbursement. Dual Medicaid enrollment is also predictive of future Medicare expenditures. Tasks to be completed in year 2002 are to analyze the predictive power of alternative risk adjusters; identify best payment risk adjusters; compare survey- and claims-based risk adjusters; conduct payment simulations; and examine potential selection bias, stability of health status measures, and decay in the predictive power of such measures.

94-125 **Florida Health Security (FHS)**

Project No.:	11-W-00025/4
Period:	September 1994–September 1999
Funding:	Waiver only
Award:	Waiver-only Project
Principal Investigator:	Tom Wallace
Awardee:	Florida's Agency for Health Care Administration The Atrium, Suite 301 325 John Cox Road Tallahassee, FL 32303-4131
HCFA Project Officer:	Alisa Adamo Office of State Health Reform Demonstrations

Description: The Florida Health Security (FHS) program will build on the State's managed competition model. It aims to test the extent to which Federal and State assistance will allow employers to provide coverage to employees and their dependents in a voluntary market. FHS is a voluntary, employer- based, discounted premium program designed to provide access to private health insurance for working uninsured Floridians. FHS will provide health insurance for 1.1 million uninsured Floridians with gross income at or below 250 percent of the Federal poverty level (certain individuals are ineligible for FHS–e.g., Medicaid and Medicare eligibles, individuals who have been insured in the previous 12 months).

The FHS program is distinctly separate from the State's traditional Medicaid program. The traditional Medicaid program will not be affected by the FHS program. However, a series of reforms will be occurring in the State's traditional Medicaid program, and these reforms should provide most of the financing for the FHS program. The reforms include mandating managed care for all traditional Medicaid eligibles and eliminating the medically needy program. Most medically needy individuals will be eligible for FHS; those who are not will be grandfathered into the traditional Medicaid program.

Under FHS, health plans (indemnity and health maintenance organization) will be offered by accountable health partnerships and administered by a network of community health purchasing alliances established to implement Florida's overall managed-competition strategy.

Status: The Federal waivers were awarded on September 15, 1994. However, the program cannot be implemented without State legislation. Depending on the outcome of the future legislative session, the program could be implemented 90 days after the legislation is approved.

93-062 Hawaii QUEST

Project No.:	11-W-00001/9
Period:	July 1993–July 1999
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Winnie Odo
Awardee:	Hawaii Department of Human Services P.O. Box 339 Honolulu, HI 96809-0339
HCFA Project Officer:	Rhonda S. Rhodes Office of State Health Reform Demonstrations

Description: Hawaii QUEST is a statewide project that creates a public purchasing pool that arranges for health care through capitated managed-care plans. Hawaii QUEST builds on Hawaii's Prepaid Health Care Act by integrating public and private programs to develop a more efficient, seamless health care delivery system for individuals previously served by three public programs: Medicaid, General Assistance, and the State Health Insurance Program. The project extends the Medicaid eligibility income limits to 300 percent of the Federal poverty level and provides a benefit package consistent with the services currently offered under Hawaii's traditional Medicaid program, including medical, dental, and behavioral health services.

Status: Hawaii QUEST was implemented on August 1, 1994. Approximately 150,000 beneficiaries are enrolled in five capitated health plans and two capitated dental plans. The State has contracted with a behavioral health managed-care plan to provide behavioral health services to adults, while children requiring these services are enrolled with the Hawaii Department of Health, Children and Adolescents Mental Health Division. Enrollment in Hawaii QUEST has been higher than originally projected for the first full operational year, and amendments to the demonstration designed to curb enrollment of the expansion population were approved. The amendments include the imposition of premiums on noncategorical individuals above the Federal poverty level, except pregnant women and children, and other cost-sharing provisions. Hawaii has completed a baseline health status survey and a beneficiary satisfaction survey. The satisfaction surveys will be fielded annually.

93-053 Issues Involved in Developing a Standardized Benefit Package

Project No.:	500-92-0024DO05
Period:	July 1993–March 1994
Funding:	$ 177,182
Award:	Delivery Order in Master Contract
Principal Investigator:	John Holahan, Ph.D.
Awardee:	The Urban Institute (See page 208)
HCFA Project Officer:	Gerald F. Riley Division of Health Information and Outcomes

Description: The investigators will explore issues related to the development of a standardized benefit package and will prepare a report discussing those issues. The exploration of the issues will consist of these specific tasks:

- A literature review of previous work in the area.
- Discussions with government and academic leaders who have theoretical and practical experience with designing benefit packages.
- Analysis of employer-sponsored benefit package data collected by the U.S. Department of Labor.

Status: A report, "Issues Involved in Developing a Standard Benefit Package," accession number PB95-103933, is available from the National Technical Information Service. Another report, "The Impact of Plan Design on the Value of Coverage: An Analysis of Four Selected Plan Designs," is available under accession number PB95-199006.

94-022 Issues Related to the Federal Government Drug Payment Policies in the Reformed Health Care Environment: Health Economics Research, Inc.

Project No.:	500-92-0020DO10
Period:	September 1994–September 1995
Funding:	$ 118,353
Award:	Delivery Order in Master Contract
Principal Investigator:	Rezaul Khandker, Ph.D.
Awardee:	Health Economics Research, Inc. (See page 206)
HCFA Project Officer:	Jay Bae, Ph.D. Division of Payment Systems

Description: The purposes of this project are to examine the effects of the current Federal drug payment policy (i.e., Medicaid rebate policy) and other related policies (e.g., formularies, prior authorization, drug utilization review) in the rapidly changing health care market environment, and to identify and analyze issues to consider in formulating efficient and equitable Federal drug payment policies for the reformed health care environment. The main difference between this project and the project by Health Economics Research, Inc., and the project awarded to KPMG Peat Marwick under the same solicitation is that this project analyzes the effects of such issues within the theoretical framework of microeconomic models of the industry and policy instruments, while the KPMG Peat Marwick project focuses on conceptual analyses of the reactions among the firms.

Status: This project was recently completed. The final report, "Issues Related to the Federal Government Drug Program Policies in the Reformed Health Care Environment," Health Economics Research, Inc., is available from the National Technical Information Services, accession number, PB-96-115712.

94-021 Issues Related to the Federal Government Drug Payment Policies in the Reformed Health Care Environment: KPMG Peat Marwick

Project No.:	500-93-0031DO02
Period:	October 1994–September 1995
Funding:	$ 128,228
Award:	Delivery Order in Master Contract
Principal Investigator:	David Gross
Awardee:	KPMG Peat Marwick
	(See page 207)
HCFA Project Officer:	Jay Bae, Ph.D. Division of Payment Systems

Description: The purposes of this project are to examine the effects of the current Federal drug payment policy (i.e., Medicaid rebate policy) and other related policies (e.g., formularies, prior authorization, drug utilization review) in the rapidly changing health care market environment, and to identify and analyze issues to consider in formulating efficient and equitable Federal drug payment policies for the reformed health care environment. The main difference between this project by KPMG Peat Marwick and the project awarded to Health Economics Research, Inc. (HERI) under the same solicitation is that this project focuses more on conceptual analyses of the industry responses to various policy instruments, while the HERI project focuses more on microeconomic modeling of the industry and theoretical discussions.

Status: This project was recently completed. The final report, entitled "Issues Related to the Federal Government Drug Payment Policies in the Reformed Health Care Environment: KPMG Peat Marwick," is available from the National Technical Information Service, accession number, PB96-115712.

94-128 Kentucky Health Care Partnership Plan Amendment

Project No.:	11-W-00005/4
Period:	October 1995–October 2001
Funding:	Waiver only
Award:	Waiver-only Project
Principal Investigator:	Masten Childers II
Awardee:	Kentucky Department for Medicaid Services Cabinet for Human Resources Frankfort, KY 40621-0001
HCFA Project Officer:	Maria Boulmetis Office of State Health Reform Demonstrations

Description: The State of Kentucky did not receive the necessary State legislation to implement the Kentucky Medicaid Access and Cost Containment demonstration, approved on December 9, 1993. On June 19, 1995, the State submitted an amendment to its proposal, entitled the Kentucky Health Care Partnership Plan. The amendment incorporates the legislature's direction to postpone expansion to new enrollees until the demonstration has been implemented and proven to be successful in providing quality, cost-effective care to the current Medicaid population. Under the amended waiver, the State will be divided into eight managed-care regions, incorporating public and private providers into a single network in order to provide beneficiaries with accessible, cost-effective care in urban and rural areas. Medicaid beneficiaries will be enrolled in the partnership designated for their area, and the benefit package will be consistent across all the partnerships. The State will phase in enrollment of Medicaid beneficiaries beginning on July 1, 1996, on a region-by-region basis. All the partnerships will be fully implemented within 18 months.

Status: The State is proceeding to complete the preimplementation activities.

95-024 MassHealth: Massachusetts Health Reform Demonstration

Project No.:	11-W-00030/1
Period:	April 1995–April 2001
Funding:	Waiver only
Award:	Waiver-only Project
Principal Investigator:	Bruce Bullen
Awardee:	Division of Medical Assistance 600 Washington Street, Boston, MA 02111
HCFA Project Officer:	Edward T. Hutton, Ph.D. Office of State Health Reform Demonstrations

Description: The Health Care Financing Administration has approved waivers for the Massachusetts' Medicaid demonstration proposal entitled "MassHealth" on April 24, 1995. Massachusetts will make comprehensive health care coverage available to approximately 1.1 million individuals, including 700,000 currently eligible for coverage under the Massachusetts Medicaid program and 400,000 who will become newly eligible. The new eligibles include 160,000 uninsured poor and low-income individuals and families at risk of losing health insurance.

The Commonwealth estimates that a majority of the uninsured under 200 percent of the Federal poverty level (FPL) will become insured through MassHealth. The other targeted populations under the demonstration include low-income short-term unemployed, working disabled adults and disabled children, populations limited by insurance administration barriers (i.e., preexisting condition exclusions and waiting periods), and small businesses and non-group members seeking purchasing leverage.

MassHealth represents a set of strategies to improve access to health insurance and to stimulate the offering of affordable coverage. The program builds on the Commonwealth's existing managed-care program, which is made up of health maintenance organizations and a Primary Care Clinician Program and existing State-only programs for the disabled and short-term unemployed. The demonstration will be composed of the six strategies, which will be partially financed by redistributing disproportionate share hospital payments. The strategies streamline eligibility for the current Medicaid program, provide health insurance for non-Medicaid-eligible disabled and the unemployed, advance existing Medicaid managed care programs, and make employer and employee subsidies available for health insurance coverage for the working poor.

Status: The State requires enabling legislation before the demonstration can be implemented.

95-017 Medicare Competitive Pricing Demonstrations

Project No.:	500-92-0014/5
Period:	September 1995–September 1997
Funding:	$ 963,550
Award:	Contract
Principal Investigator:	Robert Coulam, Ph.D., J.D.
Awardee:	Abt Associates, Inc. (See page 203)
HCFA Project Officer:	Ronald W. Deacon, Ph.D. Division of Delivery Systems and Financing

Description: Abt Associates, Inc. will assist the Health Care Financing Administration (HCFA) in the design, development, and implementation of competitive pricing demonstrations. In selected geographic areas, qualified health plans will submit price bids to provide the basic Medicare benefits. HCFA will select one of the submitted bids as the government contribution. During a coordinated open enrollment period, all Medicare beneficiaries will be given the opportunity to select one of the health plans available in their area. Health plans will receive the fixed government contribution and will charge beneficiaries any additional amounts required to cover their cost of providing the basic benefits and any additional benefits selected. Prior to the open enrollment period, all beneficiaries will receive choice counseling and educational materials about the various health plan alternatives. Beneficiaries may also elect to receive Medicare benefits through the traditional fee-for-service system.

Status: This project is a recent award. By June 1996, HCFA and Abt Associates, Inc. are expected to select demonstration sites, determine health plan qualification requirements, define the process of selecting competing price bids, and design the choice counseling and enrollment process. The demonstrations are expected to be operational by January 1997.

95-027 OhioCare

Project No.:	11-W-00023/5
Period:	January 1995–December 2000
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Bill Ryan
Awardee:	Ohio Department of Human Services 30 East Broad Street Columbus, OH 43266-0423
HCFA Project Officer:	David W. Walsh Office of State Health Reform Demonstrations

Description: The section 1115 waiver demonstration entitled "OhioCare" was approved January 17, 1995, by the Health Care Financing Administration. OhioCare is a statewide health care reform program that will expand coverage to include Ohio's uninsured population with incomes of up to 100 percent of the Federal poverty level. Ohio expects up to 500,000 additional recipients to receive Medicaid benefits under this program. Under OhioCare, the State will enroll all new eligibles and current Medicaid recipients into managed-care plans. Also, OhioCare will test the use of managed care for special health-related services currently administered by State agencies such as the Departments of Mental Health and Drug and Alcohol Addiction Services. The OhioCare demonstration expects to begin operations on July 1, 1996. Demonstration waivers have been awarded for a 5-year period.

Status: The State plans to begin operations in July 1996. Currently, the demonstration is in the preoperational phase.

93-068 Options for Federal Funding for State Costs Under Health Care Reforms

Project No.:	500-92-0024DO06
Period:	September 1993–October 1995
Funding:	$ 354,838
Award:	Delivery Order in Master Contract
Principal Investigator:	John Holahan, Ph.D.
Awardee:	The Urban Institute (See page 208)
HCFA Project Officer:	Brigid Goody, Sc.D. Division of Delivery Systems and Financing

Description: The purpose of this study is to highlight the distributional inequities inherent in the financing of the current Medicaid program, as well as to estimate the magnitude of the redistribution of Federal funds that would result from the implementation of a different reform proposals. The analysis has three phases. The first phase examines the case where the Medicaid program is maintained in its current matching program structure, but the formula for the distribution of Federal funds to states is modified. The second phase examines Medicaid's disproportionate share hospitals (DSH) program and the distribution of these funds to States. The final phase examines state financing implications of the full or partial integration of Medicaid into broad-based national health care reform.

Status: A final report, "Options for Federal Funding for State Costs Under Health Care Reform," accession number PB95-261137, is available from the National Technical Information Service. The investigators draw several conclusions about the impact of changes in the formula for distributing Federal funds across States:

- Simple changes to the formula, designed to improve the measure of state fiscal capacity, lead to substantial gains and losses by various States.
- Many of the losing States are those that currently spend less than average on their Medicaid programs.
- Given the current uneven distribution of DSH payments across States, the allocation of DSH funds using the number of uninsured persons or the number of persons below 150 percent of poverty has major redistributional effects.
- Although strategies for distributing Federal funds among States can improve cross-state equity, they are unlikely to decrease the substantial variation in State spending per beneficiary.

A draft report on the impact of swap proposals on States is currently under review.

93-038 Oregon Reform Demonstration

Project No.:	11-P-90160/0
Period:	April 1993–January 1999
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Lynn Read
Awardee:	Oregon Department of Human Resources 500 Summer Street, NE. Salem, OR 97310
HCFA Project Officer:	Bruce R. Johnson Office of State Health Reform Demonstrations

Description: The Oregon Reform Demonstration is an innovative program of private insurance reform, employer coverage, managed care, and restructured Medicaid benefits for both the Medicaid-eligible and the uninsured populations. The demonstration is scheduled to operate between February 1, 1994, and January 31, 1999. The demonstration will extend Medicaid eligibility for Oregonians whose income is below the Federal poverty level, regardless of age, sex, and family status. Since the number of persons eligible for benefits will increase substantially, Oregon will implement two mechanisms for containing costs: prioritization of condition-specific treatments and procedures that will be included in the Medicaid benefit package, and managed-care initiatives to enhance coordination of care and provide incentives for controlling costs. Mental health and chemical dependence services were incorporated into the Oregon Health Plan (OHP) benefit package for up to 25 percent of the eligible population with the implementation of Phase II in January 1995. In March 1995 Phase II eligibles, which include aged, blind, disabled, and foster-care children were added to the OHP. Nursing facilities and home- and community-based services will not be affected by the demonstration.

Status: The State began enrollment in February 1994. As of June 1995, approximately 188,000 current Medicaid eligibles and 126,000 previously uninsured individuals had enrolled in the OHP, along with 71,000 aged, blind, disabled, and foster-care children added to OHP under Phase II. The delivery system consists of 16 fully capitated health plans, 4 partially capitated physician care organizations, 7 dental care organizations, and 9 mental health organizations. There are currently 869 primary-care case managers also under contract to provide care in counties without sufficient prepaid health plans (an increase from 387 in June 1994). In the other counties where a sufficient number of plans have contracted, participants must select a plan or be assigned to one. As a result of budget cuts by the State legislature, Oregon has requested amendments to the waiver to impose additional eligibility requirements for new eligibles, impose cost-sharing provisions (i.e., premiums and copayments), and to move the funding line of covered condition/treatments, eliminating 25 previously covered services from the OHP benefit package.

94-104 **Rhode Island RIte Care**

Project No.:	11-W-00004/1
Period:	April 1994–March 1999
Funding:	Waiver only
Award:	Waiver-only Project
Principal Investigator:	Christine C. Ferguson
Awardee:	State of Rhode Island Department of Human Services 600 New London Avenue Cranston, RI 02920
HCFA Project Officer:	Deborah C. Van Hoven Office of State Health Reform Demonstrations

Description: This statewide initiative, approved in November 1993, seeks to increase access to and delivery of primary and preventive health care services for all Aid to Families with Dependent Children recipients (65,000) and to extend coverage to approximately 3,500 pregnant women and children under 6 years of age, with family incomes of up to 250 percent of the Federal poverty level (FPL). RIte Care eligibles will be required to enroll in prepaid health plans contracted with the State to provide comprehensive health services. Prepaid health plans will offer medical, dental, and mental health benefits. Long-term care services will not be provided through the plans. Plans will be required to offer participants a package of enhanced services to assist in overcoming the nonfinancial barriers to care, including home visits, nutrition counseling, childbirth education, parenting skills education, and smoking cessation. Pregnant women enrolled in RIte Care who lose eligibility 60 days post partum will be offered the opportunity to enroll in an extended family-planning program for a 2-year period. RIte Care will include a cost-sharing component. Individuals with incomes of between 185 and 250 percent of the FPL (new eligibles) will be subject to cost-sharing requirements, either through premiums or copayment arrangements. Individuals with incomes of less than 185 percent of the FPL will not be subject to any cost-sharing requirements.
Status: Enrollment in this program began August 1, 1994. As of August 1995, approximately 68,500 currently eligible women and children had been enrolled in managed-care plans, and approximately, 1,200 pregnant women and children for whom eligibility has been extended are enrolled.

94-122 **Risk-Adjusted Payment Models for the Non-Elderly**

Project No.:	18-C-90462/1
Period:	September 1994–September 1997
Funding:	$ 802,651
Award:	Cooperative Agreement
Principal Investigator:	Arlene Ash
Awardee:	Boston University 80 East Concord Street Boston, MA 02118
HCFA Project Officer:	Melvin J. Ingber Division of Delivery Systems and Financing

Description: This project will develop a revised system based on the diagnostic-cost-group (DCG) model for the population under 65 years of age that would incorporate diagnoses from both inpatient and ambulatory encounters. A similar model is being developed for the Medicare population under another project. The revised DCGs classify diagnoses by clinical and future cost implications. A hierarchy of diagnoses within body systems results in the dominance of the most serious disease in each category. There may be coded multiple comorbidities across systems, however. The project will use data from several sources: CalPers (the five largest participating plans), Medicaid Statistical Information System (three States), MedStat, and data from Massachusetts State employees and dependents. The data cover 1991–1994 and include approximately 2 million covered lives.

Status: The project is in the process of gleaning the data from multiple sources for analysis.

94-124 **Risk Adjustment of Payment for Mental Health and Substance Abuse**

Project No.:	18-C-90314/1
Period:	October 1994–January 1997
Funding:	$ 1,056,690
Award:	Cooperate Agreement

Principal Investigator:	Richard G. Frank, Ph.D.
Awardee:	Harvard Medical School 25 Shattuck Street Boston, MA 02115
HCFA Project Officer:	Yen-Pin Chiang, Ph.D. Division of Delivery Systems and Financing

Description: This risk adjustment research project attempts to study the issues that arise from providing mental health and substance abuse care coverage under a capitation system. There are three main objectives of this project. One objective is to test the ability of three risk classification systems—ambulatory care groups (ACGs), diagnostic costs groups, and payment amount for capitated systems to explain variation in mental health and substance abuse (MH/SA) costs. The project will modify the existing systems to improve their ability to explain the variation in MH/SA costs. Another objective is to collect information on private-sector cost-sharing arrangements for "carve-out" providers of MH/SA benefits. Using the information, profits and losses of different arrangements will be compared. The third objective is to develop a simulation model that is based on the risk classification systems and the private-sector cost-sharing arrangements. The project will evaluate the predictive accuracy of the hybrid simulation model for premium-setting purposes.

Status:The project has completed its data acquisition Phase in obtaining data from the Michigan and New Hampshire Medicaid programs. Private insurance data from the Mercer CHAMP system have also been acquired. The analytical file for the New Hampshire Medicaid data is completed, and preliminary analysis of the performance of the ACG classification system has been conducted based on the New Hampshire Medicaid data. Based on information gathered from State Medicaid agencies, private employers and insurance plans that have risk contract arrangements for mental MH/SA care, the awardee has submitted to Health Care Financing Administration two draft papers on the financial-risk-sharing arrangements and the quality standards in managed behavioral health care contracts.

95-022 South Carolina Palmetto Health Initiative

Project No.:	11-D-00027/4
Period:	November 1994–November 1996
Funding:	Waiver only
Award:	Waiver-only Project
Principal Investigator:	Eugene A. Laurent, Ph.D.
Awardee:	South Carolina Health and Human Services Finance Commission P.O. Box 8206 Columbia, SC 29202
HCFA Project Officer:	Sherrie L. Fried Office of State Health Reform Demonstrations

Description: The Palmetto Health Initiative (PHI) would extend health care coverage to approximately 280,000 South Carolinians by expanding eligibility guidelines to those residents at or under 100 percent of the Federal poverty level. The PHI would require that each member select either a fully capitated managed health plan or a partially capitated primary physician plan, thus giving them direct access to a primary care provider. PHI would enable South Carolina to streamline the eligibility process and reduce administrative overhead while providing better access to primary and preventive care. In addition, South Carolina proposed a 500-member pilot project to demonstrate that the total health care service needs of the population traditionally deemed to require, or to be at risk for, placement in a nursing facility can be effectively met at a lower cost through a managed care system that emphasizes home- and community-based services.

Status: The State has indefinitely postponed proceeding with the development Phase of the project.

95-020 State Health Care Reform Monitoring

Project No.:	500-92-0035/DO03
Period:	September 1995–September 1998
Funding:	$ 1,464,511
Award:	Delivery Order in Master Contract (See page 202)
Contractor:	The MedStat Group
Project Officer:	Kathy Rama Office of State Health Reform Demonstrations

Description: The purpose of this project is to assist States in implementing section 1115 health care reform demonstrations and to assist the Health Care Financing Administration (HCFA) in monitoring quality of care in these demonstrations. The MedStat Group will create three guides under the terms of this contract: the first for use by States as they develop and implement encounter data systems, the second for use by HCFA's Regional Offices in monitoring encounter data implementation by the States, and the third for the use of HCFA's Regional Offices in monitoring and quality of care in the demonstrations.

Additionally, MedStat will provide direct technical assistance to States and help them validate encounter data. MedStat will also provide training sessions on related topics to the Regional Offices in year two of the project.
Status: The contract was awarded on September 30, 1995. Preliminary planning discussions between MedStat staff and the Office of State Health Reform Demonstrations were held in October.

93-039 **State Primer on All-Payer Systems for Health Care Services** (Formerly, Assessing the Viability of All-Payer Systems for Health Care Services: Health Economics Research, Inc.)

Project No.:	500-92-0020DO04
Period:	May 1993–September 1995
Funding:	$ 337,542
Award:	Delivery Order in Master Contract
Principal Investigator:	Jerry Cromwell, Ph.D.
Awardee:	Health Economics Research, Inc. (See page 206)
HCFA Project Officer:	Jesse M. Levy, Ph.D. Division of Payment Systems

Description: Interest in health care reform has spread along multiple dimensions. In addition to national initiatives, there are State initiatives; in addition to managed care initiatives, there are single-payer, multiple-payer, and all-payer rate-setting initiatives. The purpose of this project is to produce a primer to inform States on the issues that would have to be addressed to design and implement an all-payer rate-setting system for physician and hospital services.

Status: The final report has been received and is currently under review.

94-030 **State Rural Health Network Reform Initiative: Assisting Washington Rural Communities Transition to Health Care Reform**

Project No.:	50-P-90262/0
Period:	August 1994–April 1996
Funding:	$ 350,000
Award:	Grant
Principal Investigator:	Alice James
Awardee:	Washington State Department of Health Office of Community and Rural Health P.O. Box 47834 Olympia, WA 98504-7834
HCFA Project Officer:	Sheldon D. Weisgrau Division of Delivery Systems and Financing

Description: The State Rural Health Network Reform Initiative provides grant funds to States to encourage innovations in rural health financing and delivery systems. The initiative is designed to enable States to address rural health issues within the context of comprehensive statewide health reform. Through a competitive process, $1.7 million was awarded to the States of Florida, Minnesota, Mississippi, Nebraska, North Carolina, and Washington to support the planning, development, and implementation of new financing and delivery arrangements that enhance access to health care services and maintain a viable delivery system for rural residents.

Status: This project will develop and provide education services and materials to rural communities about health reform and assist these communities in developing integrated rural health networks. The Washington Office of Community and Rural Health has provided technical assistance to communities and providers on health network organizational options, financing strategies, legal requirements, negotiating strategies, and development of practice management skills. Other activities include creating a plan for the participation of the State's Native American Tribes in health care reform activities and providing funding directly to communities to assist in network development efforts.

The State Rural Health Network Reform Initiative was designed as a 3-year program. However, funding for the second year of the program was rescinded by Congress. Participating States will close out program operations by April 1996.

94-025 **State Rural Health Network Reform Initiative: Financing Models for Florida's Rural Health Networks**

Project No.:	50-P-90257/4
Period:	August 1994–April 1996
Funding:	$ 300,000
Award:	Grant
Principal Investigator:	Wayne McDaniel
Awardee:	Agency for Health Care Administration 2727 Mahan Drive Tallahassee, FL 32308-5402
HCFA Project Officer:	Sheldon D. Weisgrau Division of Delivery Systems and Financing

Description: The State Rural Health Network Reform Initiative provides grant funds to States to encourage innovations in rural health financing and delivery systems. The initiative is designed to enable States to address rural health issues within the context of comprehensive statewide health reform. Through a competitive process, $1.7 million was awarded to the States of Florida, Minnesota, Mississippi, Nebraska, North Carolina, and Washington to support the planning, development, and implementation of new financing and delivery arrangements that enhance access to health care services and maintain a viable delivery system for rural residents.

Status: This project focuses on developing integrated financing strategies for rural networks in the context of Florida's managed competition health care reform efforts. Consistent with State legislation to promote the development of rural health networks, the Florida Agency for Health Care Administration has assisted rural networks in investigating alternative network financing strategies, developing infrastructure, and addressing legal issues. Two rural health networks have received funding from the State during the first year of the program to develop innovative network financing models.

The State Rural Health Network Reform Initiative was designed as a 3-year program. However, funding for the second year of the program was rescinded by Congress. Participating States will close out program operations by April 1996.

94-026 State Rural Health Network Reform Initiative: Minnesota Rural Health Network Reform Initiative

Project No.:	50-P-90279/5
Period:	August 1994–April 1996
Funding:	$ 325,000
Award:	Grant
Principal Investigator:	Chari Konerza
Awardee:	Minnesota Department of Health Office of Rural Health 717 Delaware Street, SE. P.O. Box 9441 Minneapolis, MN 55440-9441
HCFA Project Officer:	Sheldon D. Weisgrau Division of Delivery Systems and Financing

Description: The State Rural Health Network Reform Initiative provides grant funds to States to encourage innovations in rural health financing and delivery systems. The initiative is designed to enable States to address rural health issues within the context of comprehensive statewide health reform. Through a competitive process, $1.7 million was awarded to the States of Florida, Minnesota, Mississippi, Nebraska, North Carolina, and Washington to support the planning, development, and implementation of new financing and delivery arrangements that enhance access to health care services and maintain a viable delivery system for rural residents.

Status: The goal of this project is to assist rural communities in building the infrastructure necessary for the development and implementation of rural health networks/Community Integrated Service Networks (CISNs) in Minnesota. (A CISN is a rural network model developed by the State as part of its health reform efforts.) The Minnesota Office of Rural Health has implemented a technical assistance program for rural network/CISN development and worked with providers and communities in developing rural community-based delivery models that vary in terms of organizational structure, risk-sharing arrangements, provider configuration, and functions provided by the network/CISN. The State has started community development and facilitation efforts as preparation for implementing these rural network models at two demonstration sites.

The State Rural Health Network Reform Initiative was designed as a 3-year program. However, funding for the second year of the program was rescinded by Congress. Participating States will close out program operations by April 1996.

94-027 State Rural Health Network Reform Initiative: Mississippi Rural Health Network Reform Initiative

Project No.:	50-P-90270/4
Period:	August 1994–April 1996
Funding:	$ 240,000
Award:	Grant
Principal Investigator:	Helen Wetherbee
Awardee:	Mississippi Division of Medicaid 239 North Lamar, Suite 801 Jackson, MS 39211
HCFA Project Officer:	Sheldon D. Weisgrau Division of Delivery Systems and Financing

Description: The State Rural Health Network Reform Initiative provides grant funds to States to encourage innovations in rural health financing and delivery systems. The initiative is designed to enable States to address rural health issues within the context of comprehensive statewide health reform. Through a competitive process, $1.7 million was awarded to the States of Florida, Minnesota, Mississippi, Nebraska, North Carolina, and Washington to support the planning, development, and implementation of new financing and delivery arrangements that enhance access to health care services and maintain a viable delivery system for rural residents.

Status: The purpose of this project is to plan and develop a rural health care network with hospitals supporting primary care services in outlying areas and ensuring specialty backup and referral services in a five-county area of northwest Mississippi. The Mississippi Division of Medicaid anticipates that infrastructure development and increased coordination of providers and resources will result in enhanced access to care and a decrease in inappropriate use of medical facilities in this area of the State. In addition, the project will demonstrate the efficacy of a benefits package tailored to the population of the rural five-county area. A

network planning committee consisting of providers, consumers, and community leaders has been formed to study access problems in the region and local providers and patients have been surveyed on these issues.
The State Rural Health Network Reform Initiative was designed as a three-year program. However, funding for the second year of the program was rescinded by Congress. Participating States will close out program operations by April 1996.

94-028 State Rural Health Network Reform Initiative: Nebraska State Strategy for Building Rural Health Networks

Project No.:	50-P-90260/7
Period:	August 1994–April 1996
Funding:	$ 228,880
Award:	Grant
Principal Investigator:	David W. Palm, Ph.D.
Awardee:	Nebraska Department of Health Office of Rural Health 301 Centennial Mall South P.O. Box 95007 Lincoln, NE 68509-5007
HCFA Project Officer:	Sheldon D. Weisgrau Division of Delivery Systems and Financing

Description: The State Rural Health Network Reform Initiative provides grant funds to States to encourage innovations in rural health financing and delivery systems. The initiative is designed to enable States to address rural health issues within the context of comprehensive statewide health reform. Through a competitive process, $1.7 million was awarded to the States of Florida, Minnesota, Mississippi, Nebraska, North Carolina, and Washington to support the planning, development, and implementation of new financing and delivery arrangements that enhance access to health care services and maintain a viable delivery system for rural residents.

Status: Through this project, the Nebraska Office of Rural Health plans to develop at least three multicounty rural networks centered around the provision of primary care and preventive services and to develop guidelines for referrals between primary care physicians and specialists in these networks. The Office of Rural Health has provided technical assistance to rural providers and communities on infrastructure development and network financing options and awarded funding to assist in developing financing and delivery strategies to a rural health network encompassing an eight-county area. Physician referral guidelines are being developed with the technical assistance of a panel of physicians brought together by the Center for Rural Health at the University of North Dakota. The Nebraska Office of Rural Health also plans to build a data set and information system to track the appropriateness of health care services and referrals and identify outcomes.

The State Rural Health Network Reform Initiative was designed as a 3-year program. However, funding for the second year of the program was rescinded by Congress. Participating States will close out program operations by April 1996.

94-029 State Rural Health Network Reform Initiative: North Carolina Rural Health Network Reform Initiative

Project No.:	50-P-90277/4
Period:	August 1994–April 1996
Funding:	$ 172,964
Award:	Grant
Principal Investigator:	Torlen Wade
Awardee:	North Carolina Department of Human Resources Office of Rural Health and Resource Development 311 Ashe Avenue Raleigh, NC 27606
HCFA Project Officer:	Sheldon D. Weisgrau Division of Delivery Systems and Financing

Description: The State Rural Health Network Reform Initiative provides grant funds to States to encourage innovations in rural health financing and delivery systems. The initiative is designed to enable States to address rural health issues within the context of comprehensive statewide health reform. Through a competitive process, $1.7 million was awarded to the States of Florida, Minnesota, Mississippi, Nebraska, North Carolina, and Washington to support the planning, development, and implementation of new financing and delivery arrangements that enhance access to health care services and maintain a viable delivery system for rural residents.

Status: This initiative is designed to develop a health care reform strategy for North Carolina's underserved rural communities. The project includes an education component to assist community-based providers in considering health reform and managed-care options, development of a network-based rural reform plan focused on the creation of local systems of care, and an infrastructure development component designed to enhance administrative, data, and other local health care resources. The North Carolina Office of Rural Health and Resource Development is developing network models for the State's rural communities and has worked with community and rural health centers on managed-care and network development issues.

The State Rural Health Network Reform Initiative was designed as a 3-year program. However, funding for the second year of the program was rescinded by Congress. Participating States will close out program operations by April 1996.

93-072 **Study of State Health Care Reform Initiatives**

Project No.:	500-92-0033DO03
Period:	September 1993–October 1996
Funding:	$ 548,572
Award:	Delivery Order in Master Contract
Principal Investigator:	James Lubalin, Ph.D.
Awardee:	Research Triangle Institute (See page 202)
HCFA Project Officer:	David W. Walsh Office of State Health Reform Demonstrations

Description: The purpose of this contract is to assist the Health Care Financing Administration's (HCFA's) Office of Research and Demonstrations, and States, to develop and implement Medicaid program innovations and/or State health system reforms. The contract has three main objectives. The first is to document the progress of States that have begun reform efforts by creating a library of information that can be updated as the implementation of reform occurs. The second is to facilitate the streamlining of the section 1115 demonstration waiver process by providing recommendations to HCFA on how to revise and simplify the guidelines for project proposals, waiver cost estimates, and evaluation designs. And the third is for the awardee to provide technical assistance to States, helping them through the development of demonstration proposals, evaluation designs, and issue papers.

Status: The contract was awarded in September 1993 to Research Triangle Institute. Subcontractors include the National Academy for State Health Policy, Indiana University, and Health Economics Research, Inc. In September 1995, the contract was extended until October 31, 1996. The awardee is in the third year of operations.

94-080 **Tennessee TennCare**

Project No.:	11-W-00002/4
Period:	January 1994–December 1998
Funding:	Waiver only
Award:	Waiver-only Project
Principal Investigator:	Rusty Siebert
Awardee:	Tennessee Department of Health TennCare Bureau 344 Cordell Hull Building Nashville, TN 37247-0101
HCFA Project Officer:	Rose M. Hatten Office of State Health Reform Demonstrations

Description: TennCare is a statewide program to provide health care benefits to Medicaid beneficiaries, uninsured State residents, and those whose medical conditions make them uninsurable. Enrollment will be capped at 1,300,000. If the cap is reached, those in mandatory Medicaid coverage groups and the uninsurables will continue to be enrolled, while the currently uninsured group enrollment will be limited. All enrollees are served in capitated managed-care plans that are either health maintenance organizations or preferred-provider organizations.

Status: The program began on January 1, 1994. Current enrollment is about 1.2 million. About 350,000 of these enrollees are in the uninsured and uninsurable groups. The State is currently working on plans to provide all mental health benefits through capitated behavioral health organizations.

93-045 **Update and Revision of the Continuous Update Diagnostic Cost Group Model**

Project No.:	500-92-0020DO06
Period:	June 1993–December 1995
Funding:	$ 589,692
Award:	Delivery Order in Master Contract
Principal Investigator:	Randall Ellis
Awardee:	Health Economics Research, Inc. (See page 206)
HCFA Project Officer:	Melvin J. Ingber Division of Delivery Systems and Financing

Description: This project is to continue the development of a patient classification scheme to help determine capitated rates for Medicare health maintenance organization enrollees based on expected medical costs of enrollees. The system can be used for risk assessment of enrollees in health plans and for risk adjustment of payments to the plans.

The system, is a major revision of diagnostic cost groups. *International Classification Diseases, 9th Revision, Clinical Modification* codes for diagnoses are classified into clinically meaningful groups that have similar cost implications for the year following a 12-month data collection period. Persons are characterized by their vector-of-disease classes. Regression analysis is used to determine the future cost implications of each class and demographic variable. The estimated structure is then used to assign scores, proportional to expected costs, to persons.

A number of models have been evaluated (e.g., that ignore source of diagnosis, that use source of diagnosis in the model, that use a select list of procedures as an indicator). The principal paradigm is one of hierarchical coexisting conditions. In the model, a person may be coded for diseases in many body systems, but within each system the most serious condition is used rather than many related lesser diagnoses. A hierarchy also is used in modeling with procedures.

In addition to annually updated models, a monthly updated version is being estimated. Medicare fee-for-service data are used for development.

Status: This project is in its final phase. A final report is expected in early 1996.

95-021 **Vermont Health Access Plan**

Project No.:	11-W-00051/1
Period:	August 1995–July 2001
Funding:	Waiver only
Award:	Waiver-only Project
Principal Investigator:	Cornelius D. Hogan
Awardee:	Vermont Agency of Human Services 103 South Main Street Waterbury, VT 05671
HCFA Project Officer:	Sherrie L. Fried Office of State Health Reform Demonstrations

Description: The Health Care Financing Administration has approved Vermont's section 1115 Medicaid demonstration proposal entitled the "Vermont Health Access Plan" (VHAP). Vermont will make comprehensive health care coverage available to approximately 90,500 individuals, including 64,000 individuals currently eligible for coverage under Vermont's Medicaid program, and 26,500 uninsured poor who will become newly eligible. VHAP will implement a statewide mandatory Medicaid managed-care program. The program is expected to start on January 1, 1996, and will operate for 5 years. The demonstration will provide health care services to uninsured lower-income Vermonters (up to 150 percent of the Federal poverty level [FPL]); provide a Medicaid prescription-drug benefit to the State's lower income Medicare beneficiaries (up to 150 percent FPL); and improve access, service coordination, and quality of care through the implementation of a managed-care delivery system.

Status: Vermont is planning to implement the demonstration on January 1, 1996. They are currently in the development phase of the demonstration.

Intramural

IM-036 **Medicare SELECT Demonstration Program Evaluation: Report to Congress**

Funding:	Intramural
HCFA Project Director:	Sherry A. Terrell, Ph.D. Division of Delivery Systems and Financing
Mandate:	Omnibus Reconciliation Act of 1990 (Public Law 101-508), and the Social Security Act Amendments of 1995 (Public Law 104-18)

Description: The Secretary of the Department of Health and Human Services is required by Section 4358(d) of the Omnibus Budget Reconciliation Act of 1990 to evaluate and report to Congress on the 17-state Medicare SELECT demonstration—Alabama, Arizona, California, Florida, Illinois, Indiana, Kentucky, Massachusetts, Michigan, Minnesota, Missouri, North Dakota, Ohio, Oregon, Texas, Washington, and Wisconsin. In July 1995, Public Law 104-18 extended the demonstration to all 50 States for 3 years and required the Secretary to conduct a study comparing health care costs, quality of care, and access to services for Medicare SELECT policies with costs, access, and quality for standard Medicare supplemental policies, also known as Medigap policies. The Secretary must determine whether the SELECT demonstration program has *not* resulted in:

(1) excessive premium costs for SELECT enrollees,
(2) significant additional costs for the Medicare program, or
(3) significantly diminished access to and quality of care for SELECT enrollees, as compared to traditional Medigap enrollees. Unless the Secretary determines that one of these conditions is true, the SELECT demonstration will become a permanent national program.

Status: The evaluation upon which the Secretary's determination and Report to Congress will be based is near completion. Interim study findings have been transmitted to the Committee on Ways and Means, U.S. House of Representatives. Medicare SELECT enrollees appear to be as satisfied as standard Medigap enrollees with their quality of care and appear to have no access problems. However, even though premiums for SELECT plans are generally 10 to 30 percent lower than comparable policies for enrollees at age 65, SELECT premiums exceed those of comparable plans for enrollees by age 75, likely reflecting the practice of some SELECT plans of selling age-attained policies. The final Report to Congress is currently under review.

IM-058 **Outlier Pool Demonstration**

Award:	Intramural
HCFA Project Officer:	Ronald W. Lambert Division of Delivery Systems and Financing

Description: Four Medicare health maintenance organizations in the Seattle area (Group Health Cooperative of Puget Sound, Pacificare, Sisters of Providence, and QualMed) will participate in a demonstration to test an outlier pool payment approach. Plans will be paid at a rate of 97 percent of the adjusted average per capita cost, with 2 percent of the payments going into a pool. Plans with a higher than average incidence of high-cost cases will receive more from the pool than they paid in, and those with a lower incidence will receive less. Plans will be required to submit encounter data on all of their risk enrollees. In addition to serving as the basis for determining the costs of high-cost cases, these data will be used in the evaluation of the demonstration.

Status: Through September 30, 1995, this project was an intramural effort to establish detailed data submission requirements for the participating plans. This demonstration will be effective in 1996, contingent upon the plans meeting the Health Care Financing Administration's encounter data requirements.

Managed Care Systems

Extramural

88-001 Amalgamated Medicare Insured Group

Project No.:	95-C-99171/2
Period:	October 1987–July 1995
Funding:	$ 333,744
Award:	Cooperative Agreement
Principal Investigator:	Richard Burker
Awardee:	Amalgamated Life Insurance Company 770 Broadway New York, NY 10003
HCFA Project Officer:	Ronald W. Deacon, Ph.D. Division of Delivery Systems and Financing
Mandate:	Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203)

Description: The Amalgamated Medicare Insured Group (AMIG) is being developed by the Amalgamated Life Insurance Company (ALICO), administrators of trust funds for the Amalgamated Clothing and Textile Workers Union. The AMIG project will unify all aspects of program administration, including Medicare Parts A and B and Medicare supplemental benefits under the auspices of ALICO. Funding will be provided through a capitated rate paid by the Health Care Financing Administration, employer contributions, and enrollee premiums. By using managed health care systems and provider negotiation leverage resulting from a large retiree population, the AMIG is expected to reduce the cost to all payers.

Status: ALICO completed an initial feasibility study in 1993 and proceeded to develop an experience-based rate setting methodology and other operational aspects of the retiree demonstration. From the beginning of the initiative, ALICO experienced problems finding a health care delivery system that could complement its own primary care outpatient system. After several failed attempts to contract with hospital-based integrated delivery systems or HMOs in the Philadelphia area, ALICO decided to terminate the AMIG initiative in July 1995.

95-010 Assessment of the Impact of Pharmacy Benefit Managers

Project No.:	95-023/PK
Period:	July 1995–June 1996
Funding:	$ 213,165
Award:	Contract
Principal Investigator:	David Zimmerman, Ph.D.
Awardee:	University of Wisconsin 610 Walnut Street Madison, WI 53705-2397
HCFA Project Officer:	Kathleen Gondek, Ph.D. Division of Payment Systems

Description: The growth of managed purchasing of pharmaceuticals has risen dramatically. Today, managed purchasers include health maintenance organizations, various buying consortia of independent and/or chain pharmacies, and pharmacy benefits managers (PBMs). PBMs represent one type of provider with considerable purchasing power. They are responsible for the design, implementation, and administration of pharmacy benefits programs, largely through managed care organizations (MCOs), major manufacturers, and union groups.

The project will cover two general areas: (1) comparison of cost and quality issues for drug benefits among Medicaid fee-for-service, Medicaid Managed Care, and PBM non-Medicaid models; (2) potential impact of PBMs on the system. A comprehensive literature review will provide background and suggest a typology of PBMs, incorporating such variables as organization, growth, scope of service, and clients. To examine cost and quality issues, information will be collected using a case study approach directly from State Medicaid programs, MCOs that enroll Medicaid recipients and subcontract with PBMs, and PBMs.

Status: This project is in the development phase. The literature review and typology have been completed. Site visits will begin in late fall 1995.

95-079 Automated Control for Imaging Modalities

Project No.:	97-P-08089/6-01
Period:	June 1995–June 1996
Funding:	$ 86,311
Award:	Grant
Principal Investigator:	Robert Murry
Awardee:	BRIT Systems 1402 Corinth Street, Suite 221 Dallas, TX 75215
HCFA Project Officer:	Cheryl Sample Financial, Administrative, and Procurement Staff
Mandates:	Small Business Innovation Development Act of 1982 (Public Law 97-219; as amended by the Small Business Innovative Research Program, Extension, Public Law 99-443)

Description: The purpose of this project is to develop computer programs for automating the testing of medical diagnostic imaging equipment. The programs will run on the vast majority of existing medical image computer networks that many radiology departments already have. This development will provide testing methods for most medical image quality parameters that are much faster and less expensive than the largely manual alternative methods.

Status: The grantee is currently working on Phase I, the development phase of the project.

92-062 Case Management of Elderly at Risk for Acute Hospitalization

Project No.:	95-C-90165/5
Period:	September 1992–November 1995
Funding:	$ 131,076
Award:	Cooperative Agreement
Principal Investigator:	Larry Salwin
Awardee:	Providence Hospital 16001 West Nine Mile Road Southfield, MI 48045
HCFA Project Officer:	William L. Damrosch Division of Delivery Systems and Financing
Mandate:	Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: The demonstration is designed to evaluate the appropriateness of providing case management services for Medicare beneficiaries with catastrophic illnesses and high medical costs. Providence Hospital will provide case management services to patients with a number of diagnoses associated with high rates of hospitalization.

Status: Providence Hospital is in the process of an orderly termination of its project. All beneficiaries and physicians have been notified of the beneficiary ending dates. Enrollment of new patients was discontinued effective May 31, 1995. A preliminary report is due January 1996 with final report due April 1996.

95-074 Computer-Assisted Choice of Cost-Effective Regimens for Osteoporosis Management

Project No.:	97-P-08097/2-01
Period:	June 1995–June 1996
Funding:	$ 44,412
Award:	Grant
Principal Investigator:	Renee Arnold
Awardee:	Pharmacon International, Inc. The Empire State Building 350 Fifth Avenue, Suite 5110 New York, NY 10118
HCFA Project Officer:	Joanna Bandzwolek Financial, Administrative, and Procurement Staff
Mandates:	Small Business Innovation Development Act of 1982 (Public Law 97-219; as amended by the Small Business Innovation Research Program, Extension, Public Law 99-443)

Description: This research is to develop a tool for assisting healthcare professionals in making cost-effective decisions regarding the therapies for the management of osteoporosis.

Status: The grantee is currently working on Phase I, the development phase of the project.

95-084 Computerizing the Reports of Interpretive Tests

Project No.:	97-P-08106/3-01
Period:	June 1995–June 1996
Funding:	$ 50,000
Award:	Grant
Principal Investigator:	John G. Sotos

Awardee: MVBS Inc.
4401 Roland Avenue, Suite 414
Baltimore, MD 21210
HCFA Project Officer: Cheryl Sample
Financial, Administrative, and Procurement Staff

Mandates: Small Business Innovation Development Act of 1982 (Public Law 97-219; as amended by the Small Business Innovation Research Program, Extension, Public Law 99-443)

Description: The grantee will develop and test a system for computerizing the reports of two medical tests involving cognitively complex domains, echocardiography, and upper gastrointestinal endoscopy.

Status: The grantee is currently working on Phase I, the development phase of the project.

95-077 Conversion 2000

Project No.: 97-P-08117/3-01
Period: June 1995–June 1996
Funding: $ 48,620
Award: Grant
Principal Investigator: Willard Lee Anderson, II
Awardee: Anderson Consulting and Computer Services, Inc.
120 Woodland Farms Road
Pittsburgh, PA 15238
HCFA Project Officer: Cheryl Sample
Financial, Administrative, and Procurement Staff

Mandates: Small Business Innovation Development Act of 1982 (Public Law 97-219; as amended by the Small Business Innovation Research Program, Extension, Public Law 99-443)

Description: The purpose of this project is to define a system for health care management that ensures the best opportunity for providing a high quality of care for Medicare and Medicaid recipients and simultaneously provides a framework to establish mechanisms for efficient medical management using currently available technology.

Status: The grantee is currently working on Phase I, the development phase of the project.

95-061 Demonstration of Integrated Care Management Systems for High-Cost/High-Risk Medicaid Beneficiaries

Project No.: 11-W-00035/3-01
Period: October 1995–October 2000
Funding: Waiver Only
Award: Grant
Principal Investigator: Martin P. Wasserman, M.D., J.D.
Awardee: Department of Health and Mental Hygiene
State of Maryland
201 West Preston Street
Baltimore, MD 21201
HCFA Project Officer: William D. Clark
Division of Aging and Disability

Description: Maryland is testing a new case-management delivery system for high-cost/high-risk Medicaid beneficiaries and those at risk to become high-cost. The program seeks to maintain or improve access to providers and the quality of the care provided. The demonstration also should lower health care costs by reducing hospital readmission rates and by maintaining patients in the lowest cost medically appropriate setting. The University of Maryland Baltimore County Center for Health Program Development and Management, under contract to the State, is responsible for the demonstration's operations.

Status: This project was approved in October 1995 and will engage in a preimplementation development phase prior to operations in 1996.

92-060 Demonstration Project to Case Manage Medicare Beneficiaries with Catastrophic and Chronic Conditions Residing in the State of Indiana

Project No.: 95-C-90163/5
Period: September 1992–November 1995
Funding: $ 343,997
Award: Cooperative Agreement
Principal Investigator: Mary Jane Teirumniks
Awardee: AdminaStar Solutions
9525 Delegates Row
Indianapolis, IN 46240
HCFA Project Officer: William L. Damrosch
Division of Delivery Systems and Financing

Mandate: Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: The demonstration is designed to evaluate the appropriateness of providing case management services for Medicare beneficiaries with catastrophic illnesses and high medical costs. AdminaStar will provide case management services to patients with congestive heart failure.

Status: The total enrollment of beneficiaries by AdminaStar as of July 1995 was 1,133, while active participants numbered 350. This project ends in November 1995 with a final report due in 1996. An evaluation will be completed by Mathematica Policy Research Inc. in 1996.

95-080 Design of Specialized Protocol Software to Monitor Health Care and Case Management Data

Project No.:	97-P-08112/8-01
Period:	June 1995–June 1996
Funding:	$ 50,000
Award:	Grant
Principal Investigator:	Jerry H. Kogan
Awardee:	CK Computer Consultants 210 North Higgins, Suite 334 Missoula, MT 59802
HCFA Project Officer:	Cheryl Sample Financial, Administrative, and Procurement Staff
Mandates:	Small Business Innovation Development Act of 1982 (Public Law 97-219; as amended by the Small Business Innovation Research Program, Extension, Public Law 99-443)

Description: This project addresses the need to develop products that help all participants in health care to assess and monitor the quality and level of care furnished to patients. Computer software designed to monitor health care data can provide vital assistance to this end.

Status: The grantee is currently working on Phase I, the development phase of the project.

92-013 Effect of Market Structure on Health Maintenance Organization Financial Performance

Project No.:	17-C-90055/3
Period:	February 1992–February 1994
Funding:	$ 171,860
Award:	Cooperative Agreement
Principal Investigator:	Douglas Wholey
Awardee:	Carnegie Mellon University 5000 Forbes Avenue Pittsburgh, PA 15213
HCFA Project Officer:	Gerald F. Riley Division of Health Information and Outcomes

Description: The health maintenance organization (HMO) industry has expanded substantially over the past 10 years. This has led to substantially more competitive local HMO markets and a significant change in HMO demographics, with independent practice associations now the most prevalent HMO type. A result of these competitive changes is the increasingly restrictive State financial regulations. Research on HMO premiums and costs has not focused on the effects of these substantially different environments; thus little is known about the effects of market structure and State regulations on HMO premiums and costs. The purposes of this study are to determine whether competition among HMOs can result in beneficial effects for health care consumers through lower premiums and costs; estimate the financial effects of some specific State regulations on premiums and costs; and estimate the impact of competition and regulation on the marginal costs of providing health care to individuals under and over 65 years of age. The investigators will examine these questions for all HMOs operating during the period from 1988 to 1991, using data from financial statements filed by HMOs with State regulators and using measures of market structure developed in previous research.

Status: The final report, "The Effect of Market Structure on HMO Financial Performance: Final Report," is available from the National Technical Information Service, accession number PB95-221206.

93-075 Evaluation of Cost Health Maintenance Organizations and Health Care Prepayment Plans

Project No.:	500-92-0011DO03
Period:	September 1993–March 1996
Funding:	$ 538,869
Award:	Delivery Order in Master Contract
Principal Investigator:	Randall S. Brown, Ph.D.
Awardee:	Mathematica Policy Research, Inc. (See page 204)
HCFA Project Officer:	Ronald W. Lambert Division of Delivery Systems and Financing

Description: The awardee will evaluate the cost-effectiveness of cost health maintenance organizations (HMOs) and health care prepayment plans (HCPPs) compared with fee-for-service and risk HMOs. A separate assessment of organizations that have recently converted from the risk option to either of the cost-based options will be conducted. The main question for this assessment is whether the Health Care Financing Administration would

have saved or lost money had these organizations remained risk contractors. A case study of HCPPs will be conducted to determine the operational characteristics of the various types of HCPPs. The evaluator will examine how HCPPs coordinate the delivery of health services, given that it is not subject to the same regulatory requirements as risk or cost contractors.

Status: The case study of HCPPs has been conducted. The results are reported in an interim report. The cost effectiveness analysis is in process. The final report is due in March 1996.

93-073 Evaluation of Medicaid-Managed Care Programs with 1915(b) Waivers

Project No.:	500-92-0033DO02
Period:	September 1993–May 1996
Funding:	$ 752,256
Award:	Delivery Order in Master Contract
Principal Investigator:	James Lubalin, Ph.D.
Awardee:	Research Triangle Institute (See page 202)
HCFA Project Officer:	James P. Hadley Office of State Health Reform Demonstrations

Description: The purpose of this contract is to design and conduct an evaluation of the Medicaid managed-care initiatives implemented through 1915(b) waivers. The evaluation will provide information to the Health Care Financing Administration and the States on the extent to which various features of the managed-care projects contribute to the ability of the Medicaid program to deliver cost-effective care to Medicaid-eligible populations. The evaluation will use interview data, studies submitted by the States as part of their waiver applications, and individual level use and cost data to examine the cost-effectiveness of the projects, as well as the quality of care and satisfaction experienced by enrollees in the managed-care programs relative to a fee-for-service alternative.

Status: The evaluation is examining 1915(b) programs in California, Florida, New Mexico, Ohio, Washington, New York, and Wisconsin. Analyses of each of these programs based on case study data are being completed and will be available by the end of 1995. Secondary data related to use and cost-of-services are currently being obtained from California, Florida, New Mexico, and Ohio for analysis. The final report, containing a synthesis of case study and secondary data analyses, will be completed May 1996.

93-031 Evaluation of Medicare SELECT

Project No.:	500-93-0001
Period:	February 1993–February 1996
Funding:	$ 1,179,448
Award:	Contract
Principal Investigator:	Steven Garfinkel, Ph.D.
Awardee:	Research Triangle Institute P.O. Box 12194 Research Triangle Park, NC 27709-2194
HCFA Project Officer:	Sherry A. Terrell, Ph.D. Division of Delivery Systems and Financing
Mandate:	Section 4358(d) of the Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: Medicare SELECT is a pilot Medicare supplemental insurance product under which full Medigap benefits are paid only when services are provided by the plan's provider network. The evaluation will consist of two components. First, case studies of each of the 15 States—Alabama, Arizona, California, Florida, Illinois, Indiana, Kentucky, Massachusetts, Minnesota, Missouri, North Dakota, Ohio, Texas, Washington, and Wisconsin—which operate Medicare SELECT plans, will describe all aspects of the development and operational processes used by the State Insurance Commissioners, the National Association of Insurance Commissioners, and insurers to implement the Medicare Select provisions. Second, an analytical component will compare various measures associated with Medicare Select to other Medigap options. Measures will include cost and use of Medicare and supplemental services, selection effects, beneficiary satisfaction, and physician practice patterns.

Status: This project is near completion. A final descriptive report, "Evaluation of the Medicare SELECT Amendments: Case Study Report," is available from the National Technical Information Service, accession number PB95-201489. A beneficiary survey was conducted in 6 of the 15 States—Alabama, Arizona, Florida, Missouri, Texas and Wisconsin to determine satisfaction, access to services, and quality of care received. Of beneficiaries identified by Medicare SELECT insurers as SELECT enrollees, 23 percent did not know they were in Medicare SELECT plans. Compared to the nationwide population of Medicare beneficiaries with standard Medigap policies, SELECT enrollees were younger and more likely to be male, Black,

Hispanic and to report lower incomes and education. There was little difference in SELECT and comparison group enrollees on four measures of self-reported health status. The cost of the premium was the most important factor in enrollees' choice of SELECT policies. In every State, SELECT enrollees were satisfied or very satisfied with their Medicare supplemental plan. An insurer survey of all HMOs and Medigap insurers that did *not* participate in the SELECT program has also been completed. The most important reasons for not offering SELECT plans were preference for Medicare HMO products and competing priorities for HMOs and insurers, respectively. A comparison of premiums standardized on age, gender, and risk factors indicates that where the same standardized plan is offered by an insurer, SELECT premiums for a 65 year old are almost always lower by 10 to 30 percent. However, by age 75, SELECT premiums exceed those of comparison plans, likely reflecting the practice by some SELECT plans of selling age-attained policies.

92-024 Evaluation of the Maryland Access to Care Demonstration: Managed Care for Medicaid Recipients

Project No.:	18-C-99142/3
Period:	February 1992–September 1995
Funding:	$ 225,275
Award:	Cooperative Agreement
Principal Investigator:	Julie A. Schoenman, Ph.D.
Awardee:	The People-to-People Health Foundation, Inc. Center for Health Affairs 7500 Old Georgetown Road, Suite 600 Bethesda, MD 20814-6133
HCFA Project Officer:	Paul J. Boben, Ph.D. Office of State Health Reform Demonstrations

Description: The awardee will evaluate the Maryland Access to Care (MAC) demonstration, which became operational in December 1991, and had nearly 110,000 Medicaid recipients enrolled as of April 1992. The demonstration will eventually cover about two-thirds of all Medicaid recipients. The targeted population will be Aid to Families with Dependent Children recipients, Supplemental Security Income (SSI) recipients, and Sixth Omnibus Budget Reconciliation Act-eligible children. The MAC program is mandatory for recipients in the MAC-eligible categories. The program matches MAC recipients with a primary medical provider (PMP) that acts as the recipient's gatekeeper to the health care system. These PMPs continue under standard fee-for-service reimbursement systems but, to encourage their participation, Medicaid fees for primary care services have been increased by an average of 50 percent. Specialists are reimbursed for nonemergency specialty care provided to MAC patients only if these services are referred by the patients' PMPs. The evaluation will employ a pre- /post-test comparison and a post-test description of program operations. The data to be used will primarily be Medicaid enrollment and claims files and provider surveys.

Status: Work continues on obtaining and analyzing data from the second year of the demonstration. Originally scheduled to end in February 1995, the period of this cooperative agreement was extended to September 30, 1995 at no cost to the Federal Government. An additional no-cost extension has been requested through February 29, 1996, to allow the performance of additional analyses to compare the performance of office-based and hospital outpatient providers under the MAC program.

93-056 Evaluation of the Medicare Case Management Demonstrations

Project No.:	500-92-0011DO02
Period:	July 1993–December 1996
Funding:	$ 700,846
Award:	Delivery Order in Master Contract
Principal Investigator:	Jennifer Shore
Awardee:	Mathematica Policy Research, Inc. (See page 204)
HCFA Project Officer:	Leslie M. Greenwald, Ph.D. Division of Delivery Systems and Financing
Mandate:	Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: The purpose of this contract is to evaluate the three Medicare Case Management Demonstrations. These demonstrations are designed to evaluate the appropriateness of providing case management services for Medicare beneficiaries with catastrophic illnesses and high medical costs. Specifically, this evaluation will test the operational feasibility and cost effectiveness of case management as a way of controlling Medicare beneficiaries' catastrophic health care costs in the Medicare fee-for-service sector.

Status: The evaluation contract was awarded on August 1, 1993. Mathematica Policy Research, Inc. is in the third year of the evaluation.

95-018 Evaluation of the Medicare Choice Demonstration

Project No.:	500-92-0011/6
Period:	September 1995–June 1998
Funding:	$ 1,591,240
Award:	Contract
Principal Investigator:	Lyle Nelson, Ph.D.

Awardee:	Mathematica Policy Research, Inc. 600 Maryland Ave. Washington, DC 20024
HCFA Project Officer:	Yen-Pin Chiang, Ph.D. Division of Delivery Systems and Financing

Description: The Health Care Financing Administration (HCFA) is in the process of implementing the Medicare Choice Demonstration to test the feasibility and desirability of new types of managed care plans for Medicare such as integrated delivery systems and preferred provider organizations. The purpose of this evaluation project is to provide a detailed assessment of the overall demonstration project, which looks specifically at beneficiary experiences in the demonstration, cost and use of services within the demonstration sites, and quality of care issues. The evaluation will provide some insights as whether the greater range of managed care options offered in this demonstration would be more appealing to the Medicare beneficiaries, and whether issues such as biased selection, high rates of disenrollment and dissatisfaction exist. In addition, the evaluation project will provide continuous monitoring of the demonstration sites, including a comprehensive case study of each of the managed care plan in the demonstration. This part of the evaluation activities will focus on the implementation experience and operational feasibility of the new managed care plans, as well as how plans interact with carriers and the HCFA.

Status: This project is a recent award and it is in the early development stage.

91-014 Evaluation of United Mine Workers of America Demonstration

Project No.:	500-87-0030TO11
Period:	June 1991–January 1995
Funding:	$ 457,040
Award:	Technical Support: Evaluation of Demonstrations
Principal Investigator:	William D. Marder, Ph.D.
Awardee:	Abt Associates, Inc. 55 Wheeler Street Cambridge, MA 02138
HCFA Project Officer:	Ronald W. Lambert Division of Delivery Systems and Financing

Description: The awardee will evaluate the United Mine Workers of America (UMWA) Health and Retirement Funds (the Funds) Medicare Part B capitation demonstration. This demonstration replaces the Funds' Health Care Prepayment Plan arrangement with the Health Care Financing Administration (HCFA), in which it is reimbursed for Medicare Part B services on a cost basis. In its place, the Funds will assume risk for Medicare Part B services under a capitated payment mechanism. The issues to be addressed are these:

- An assessment of the cost-effectiveness of capitation based on an analysis of changes in utilization and cost resulting from the demonstration.
- A detailed case study describing the cost management programs and changes occurring in the organization as a result of the demonstration.

Status: Abt Associates, Inc., has completed this evaluation. Based on its approach, Abt Associates, Inc. was unable to discern a causal relationship between the demonstration and the events that occurred subsequent to its implementation. Events that happened during the demonstration may have been independent or could have been related in complicated ways. Thus, in the interim report Abt Associates, Inc. concluded that the demonstration had no measurable operational effect on the Funds beyond the obvious effect of ending the reimbursement dispute between HCFA and the Funds. In the final report, Abt Associates, Inc., concluded that there was no evidence to clearly support a conclusion about the cost-effectiveness of capitation for Funds' beneficiaries.

92-037 Evaluation of the Utah Prepaid Mental Health Plan: Coordinated Care Systems as Alternatives to Traditional Fee for Service

Project No.:	18-C-90035/5
Period:	May 1992–December 1995
Funding:	$ 412,154
Award:	Cooperative Agreement
Principal Investigator:	Jon Christianson, Ph.D.
Awardee:	University of Minnesota 1100 Washington Avenue South Minneapolis, MN 55415-1226
HCFA Project Officer:	Paul J. Boben, Ph.D. Office of State Health Reform Demonstrations

Description: The awardee will evaluate Utah's implementation of a mental health maintenance organization for its Medicaid beneficiaries. Under a section 1915 waiver from the Health Care Financing Administration, the State has signed contracts with three community mental health centers to provide mental health services to all Medicaid beneficiaries in their catchment areas, which include 52 percent of all Medicaid beneficiaries in Utah, in return for capitated payments. The State hopes that this prepaid program will control the rapidly inflating costs of inpatient mental health care in its Medicaid program, while improving patient outcomes. The evaluation will examine how

capitated rates are determined, beneficiaries are enrolled, and contracts are enforced. The evaluation also will examine the impact of the demonstration on the use and cost of mental health care received by Medicaid beneficiaries. The evaluation will use a mix of qualitative and quantitative research methodologies. Qualitative research methods will be used to assess the impact of Medicaid operations and the payment structure. The use and cost analysis will use quantitative research methodologies based on Medicaid claims and payment data. The National Institute of Mental Health is funding a companion study of the Utah program to examine the impact of the demonstration on a subgroup of high-risk beneficiaries—those individuals diagnosed as suffering from schizophrenia.

Status: The period of performance for this cooperative agreement has been extended to December 31, 1995, at no additional cost to the Federal Government. Due to problems in transmitting the necessary data from the State to the awardee, no additional reports have been received this year.

93-018 Integrated Information System for the Electronic Transfer and Validation of Provider Credentials for Coordinated Care Plans

Project Nos.:	97-P-08080/3-01 (Phase I) 97-P-08080/3-02 (Phase II)
Period:	February 1993–January 1994 (Phase I) February 1994–January 1995 (Phase II)
Funding:	$ 35,000 (Phase I) $ 150,000 (Phase II)
Award:	Grant
Principal Investigator:	Edward T. Porcaro
Awardee:	Credential Assurance Group of America 2650 Woodley Place, NW. Washington, DC 20008
HCFA Project Officer:	Carl S. Hackerman Financial, Administrative, and Procurement Staff
Mandates:	Small Business Innovation Development Act of 1982 (Public Law 97-219; as amended by the Small Business Innovation Research Program, Extension, Public Law 99-443)

Description: This project studies the need for and feasibility of establishing an automated information system to electronically transfer and validate provider credentials for coordinated care plans. It also will evaluate the current technological capabilities of coordinated care plans to collect and transmit information.

Status: This project is in Phase II (testing and data gathering phase). Because the Small Business Innovation Research program sponsors the development of commercially viable products, it carefully protects the developer's intellectual property. Any detailed information on this project and the product must be obtained from the awardee.

95-081 Interactive Computerized Program to Assist Medicare Beneficiaries in Evaluating Medigap Options

Project No.:	97-P-08133/3-01
Period:	June 1995–June 1996
Funding:	$ 46,450
Award:	Grant
Principal Investigator:	Leonard Greenberg
Awardee:	LBD Associates 203 North Aspen Avenue Sterling, VA 20164
HCFA Project Officer:	Cheryl Sample Financial, Administrative, and Procurement Staff
Mandates:	Small Business Innovation Development Act of 1982 (Public Law 97-219; as amended by the Small Business Innovation Research Program, Extension, Public Law 99-443)

Description: This project proposes a program for evaluating Medicare supplemental insurance options. The program will be designed to operate interactively based on minimal input from the beneficiary and maximum use of archived information concerning January 31, 1996 Medicare fee schedules, deductibles, copayments, and the like. A prototype program will be developed in this phase and at least partially tested.

Status: The grantee is currently working on Phase I, the development phase of the project.

95-078 Investigation System for Health Care Fraud and Abuse

Project No.:	97-P-08124/3
Period:	June 1995–June 1996
Funding:	$ 46,650
Award:	Grant
Principal Investigator:	Robert D. Smith
Awardee:	Anthem Corporation 12020 Sunrise Valley Drive Reston, VA 22091

HCFA Project Officer: Cheryl Sample
Financial, Administrative, and Procurement Staff

Mandates: Small Business Innovative Development Act of 1982 (Public Law 97-219; as amended by the Small Business Innovation Research Program, Extension, Public Law 99-443)

Description: The purpose of this project is to evaluate the feasibility of using artificial intelligence software to assist in the identification, investigation, and prosecution of health care fraud and abuse. The technical approach to be employed calls for the selection of a subset of fraud and abuse schemes related to home health care and the identification of indicators associated with these schemes.

Status: The grantee is currently working on Phase I, the development phase of the project.

92-061 Iowa Foundation for Medical Care Case Management Demonstration

Project No.: 95-C-90164/7
Period: September 1992–September 1995
Funding: $ 132,282
Award: Cooperative Agreement
Principal Investigator: Karen Coburn
Awardee: Iowa Foundation for Medical Care
6000 Westown Parkway, Suite 350E
West Des Moines, IA 50265-7771
HCFA Project Officer: William L. Damrosch
Division of Delivery Systems and Financing

Mandate: Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: The demonstration is designed to evaluate the appropriateness of providing case management services for Medicare beneficiaries with catastrophic illnesses and high medical costs. The Iowa Foundation for Medical Care will provide case management services to patients with one of two chronic conditions: chronic obstructive pulmonary disease and congestive heart failure. These conditions are diseases with known treatment variability and frequent rehospitalizations.

Status: This project has been completed. The evaluation is being carried out by Mathematica Policy Research Inc., and will be completed in 1996.

90-042 John Deere and Company Medicare Insured Group Research and Demonstration Project

Project No: 95-C-99624/5
Period: August 1990–August 1996
Funding: $ 395,959
Award: Cooperative Agreement
Principal Investigator: Mel Scott
Awardee: John Deere and Company
John Deere Road
Moline, IL 61265
HCFA Project Officer: Ronald W. Deacon, Ph.D.
Division of Delivery Systems and Financing

Mandate: Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203)

Description: John Deere and Company (Deere) will conduct an initial feasibility study that includes collecting and analyzing historical trends of the cost and use of Medicare and Deere supplemental retiree benefits. If Deere determines that the Medicare insured group (MIG) concept is a financially feasible venture, it will design the specifics of the MIG demonstration, including the eligible retiree population, benefit package, rate-setting methodology, and approval of the health care delivery system.

Status: Deere completed the feasibility study in August 1991. Managed care initiatives would reduce Deere's costs for retirees by 7.3 percent, or 2.3 percent more than the amount retained by Medicare. Deere is proceeding to develop the specific operational tasks of the MIG Demonstration and anticipates enrollment of retirees residing in the Quad Cities area of Iowa and Illinois by April 1996.

92-009 Medicaid-Capitated Managed-Care Program for Supplemental Security Income Disabled

Project No.: 18-C-90096/1
Period: February 1992–October 1993
Funding: $ 295,677
Award: Cooperative Agreement
Principal Investigator: Helen Batten, Ph.D.
Awardee: Brandeis University
Heller Graduate School
Institute for Health Policy
415 South Street
P.O. Box 9110
Waltham, MA 02254-9110

HCFA Project Officer: Rose M. Hatten
Office of State Health Reform Demonstrations

Description: The objective of the project is to compare four types of health plans in terms of services provided to Supplemental Security Income (SSI) disabled participants in Medicaid. The project examines mandatory managed-care capitated plans, mandatory fee-for-service, managed-care plans, and voluntary managed-care plans. A mail/telephone survey of administrators at an anticipated 100 plans currently offering services to SSI-disabled consumers was conducted, followed by case studies of two examples of each of the four types of plans.

Status: The final report was received in September 1995. The case study results indicate that the types of managed care plans available vary considerably.

92-023 Medicaid Capitation Rate Development

Project No.: 18-C-90135/3
Period: February 1992–December 1995
Funding: $ 473,326
Award: Cooperative Agreement
Principal Investigator: Gordon Trapnell
Awardee: Actuarial Research Corporation
6928 Little River Turnpike, Suite E
Annandale, VA 22003
HCFA Project Officer: Ronald W. Lambert
Division of Delivery Systems and Financing

Description: This project will develop a methodology that can be replicated by States to set capitation rates for Medicaid coordinated care plans. The project will be conducted in two phases. In the first phase, the quality of data from the Health Care Financing Administration's (HCFA's) Medicaid Statistical Information System (MSIS) will be examined for three States to determine whether these data are appropriate for capitation rate development. If MSIS data quality is not suitable, recommendations will be made regarding how the problems might be dealt with. HCFA will then decide whether to proceed to the methodology development phase. The second phase will involve the development of actuarial methods needed to set the rates. Separate rate cells will be developed for categories of enrollees that can have a large impact on overall payment to a plan. The methods for database creation and rate setting will be published in a manual that the States can use.

Status: The project is in the second phase. The awardee has submitted the draft rate-setting manual and the draft final report for HCFA review.

95-083 Medical Claims Analysis Using Artificial Neural Network Pattern Recognition Methods

Project No.: 97-P-08091/4-01
Period: June 1995–June 1996
Funding: $ 55,844
Award: Grant
Principal Investigator: Steven M. Epstein
Awardee: Med-AI, Inc.
602 Courtland Street, Suite 400
Orlando, FL 32804
HCFA Project Officer: Cheryl Sample
Financial, Administrative, and Procurement Staff

Mandates: Small Business Innovative Development Act of 1982 (Public Law 97-219; as amended by the Small Business Innovation Research Program, Extension, Public Law 99-443)

Description: In this project, the ability to recognize suitability patterns in Medicare and other medical claims data will be demonstrated by employing artificial neural network pattern recognition methods. The project will identify patterns such as whether the procedure is appropriate for the reported diagnosis, whether the patient demographics are appropriate for the reported diagnosis, or whether the charges claimed are reasonable for the intervention and treatments reported.

Status: The grantee is currently working on Phase I, the development phase of the project.

94-103 Medicare End Stage Renal Disease Capitation Demonstration

Project No.: 500-94-0043DO02
Period: September 1994–September 1997
Funding: $ 499,444
Award: Delivery Order in Master Contract
Principal Investigator: Stanley Wallack, Ph.D.
Awardee: Brandeis University
(See page 203)
HCFA Project Officer: Bonnie M. Edington
Division of Health Information and Outcomes

Description: The Omnibus Budget Reconciliation Act of 1993 extended the Social Health Maintenance Organization Demonstration and provided for additional sites, which included a site providing services to Medicare end stage renal disease (ESRD) beneficiaries under a capitated payment system. The purpose of this

contract is to assist the Health Care Financing Administration (HFCA) in developing, implementing, and monitoring a 3-year demonstration intended to provide health services to Medicare ESRD beneficiaries under a capitated payment plan. Also, because this demonstration is congressionally mandated and requires a Report to Congress (RTC), the awardee will be responsible for providing information to the Office of Research and Demonstrations for preparing the interim RTC. The awardee is developing a solicitation for an ESRD Managed Care Demonstration under which HCFA will pay an all-inclusive capitation rate based on 100 percent of the average adjusted per capita cost for ESRD patients and adjusted for treatment status (maintenance dialysis, transplant episode, or functioning graft), age, and whether diabetes was the cause of renal failure. All Medicare-covered services and additional benefits are to be provided under the demonstration. HCFA's intent in providing a capitated payment is to promote efficiency and quality in health service delivery to Medicare ESRD beneficiaries. It is expected that a capitated payment system will facilitate flexibility in managing the beneficiaries' medical care and will reduce Medicare's administrative costs and lessen the burden to the Medicare program, physicians, and beneficiaries. Cooperative agreement awards will be made to selected provider organizations to operate the demonstration. A separate procurement action will award a contract to evaluate the demonstration. The evaluation will assess the quality of care and health outcomes of ESRD patients under a capitated payment system, as well as the feasibility and cost effectiveness of this rate-setting system for ESRD managed care.

Status: The *Federal Register* notice for the demonstration and an informational mailing to organizations expected to be interested are planned for fall 1995. The application packet will be mailed to requesters subsequently, and proposals are expected early in 1996, with cooperative agreement awards anticipated in spring 1996. Awardees are expected to implement the demonstration 9 to 12 months after award.

82-002 **Minnesota Prepaid Medicaid Demonstration**

Project No.:	11-C-98223/5
Period:	June 1982–June 1995
Funding:	Waiver only
Award:	Cooperative Agreement
Principal Investigator:	Helen M. Yates
Awardee:	Minnesota Department of Human Services 444 Lafayette Road St. Paul, MN 55101
HCFA Project Officer:	Rhonda S. Rhodes Office of State Health Reform Demonstrations

Description: The Minnesota Prepaid Medicaid Demonstration project is one of the five original section 1115 competition demonstrations authorized by the Health Care Financing Administration to examine cost-effective alternatives for payment and delivery of Medicaid services. Under the Minnesota project, eligible individuals receive Medicaid services through prepaid, capitated, managed-care plans. The demonstration serves the Aid to Families with Dependent Children population, needy children, pregnant women, and the elderly; individuals who are under 65 and certified as disabled are exempt from the demonstration, as are qualified Medicare beneficiaries not otherwise eligible for Medicaid. The State pays a capitated rate to health plans based on the State's historical cost experience with groups of beneficiaries and other cost and utilization factors. A rate-cell approach is being used, with adjustments for age, sex, category of eligibility, county of residence, and institutional and Medicare status. Nursing facility costs are not included in the rate.

Status: The project began in July 1985 in three counties (Hennepin, Dakota, and Itasca). In April 1993 the demonstration was expanded to a fourth county (Ramsey), and in 1995 enrollment was completed in an additional four counties (Anoka, Carver, Scott, and Washington). Approximately 142,000 Medicaid beneficiaries are receiving services under the demonstration. The Prepaid Medicaid Demonstration was scheduled to end in December 1988, but through various legislative acts, Congress extended the demonstration until June 1996. This project was included in an earlier evaluation conducted by Research Triangle Institute. In April 1995, the project was amended to become the Minnesota Prepaid Medical Assistance Plus Demonstration, with an effective date of July 1, 1995.

95-029 **Minnesota Prepaid Medical Assistance Project Assistance Plus (PMAP+)**

Project No:	11-W-00039/5
Period:	July 1995–June 1998
Funding:	Waiver only
Award:	Waiver
Principal Investigator:	Bernadette G. Greene
Awardee:	Minnesota Department of Human Services 444 Lafayette Road St. Paul, MN 55101
HCFA Project Officer:	Rhonda S. Rhodes Office of State Health Reform Demonstration

Description: The Minnesota Prepaid Medical Assistance Project Plus (PMAP+) amended the Minnesota Medicaid Demonstration by expanding the project in both size and scope. The demonstration will expand to nine additional counties and will expand Medicaid eligibility to include

children and families currently covered under the State MinnesotaCare program. PMAP+ will also implement a prepaid dental program and children's mental collaboratives, and will enroll persons with disabilities in Itasca County in PMAP+. These requested changes to the original Medicaid demonstration are part of a series of health care reform measures enacted by the State to improve health care quality and create a seamless system of care for its population. The MinnesotaCare Acts of 1992, 1993, and 1994 call for specific changes in the health care delivery and financing system, and Phase I involves the integration of low-income and uninsured programs and the expansion of managed care. Under the PMAP+ demonstration the State will proceed with Phase I and is working with the Health Care Financing Administration (HCFA) to develop Phase II of the project, which would further streamline all publicly funded health care programs in the State.

Status: HCFA's approval of PMAP+ allows the State to expand into the counties of Aitken, Cook, Koochinching, Benton, Sherburne, and Stearns, St. Louis, Lake, and Carlton. The State has formed County Development Teams for the central and northeast areas of the State to assure a smooth transition to managed care in each of the counties slated for expansion. The State has begun preliminary planning for the children's mental health collaboratives and has awarded planning grants to 20 collaboratives serving 32 counties. The State has submitted a PMAP+ implementation workplan and an expansion schedule for HCFA approval.

79-001 **Municipal Health Services Program: Baltimore, Maryland** (Formerly, Municipal Health Services Program)

Project No.:	95-P-51000
Period:	August 1979–December 1997
Funding:	Waiver only
Award:	Service Agreement
Principal Investigator:	Bernadette G. Greene
Awardee:	City of Baltimore 111 North Calvert Street Baltimore, MD 21202
HCFA Project Officer:	Spike Duzor Office of Research and Demonstrations Support

Description: Development of the Municipal Health Services Program (MHSP) was a collaborative effort of four major cities, the U.S. Conference of Mayors, the American Medical Association, the Robert Wood Johnson Foundation (RWJF), and the Health Care Financing Administration (HCFA). It was initiated by RWJF through grants of $3 million awarded in June 1978 to each of these cities: Baltimore, Cincinnati, Milwaukee, and San Jose. HCFA joined the project by providing Medicare and Medicaid waivers to test the effects of increased use of municipal health centers by eliminating coinsurance and deductibles, expanding the range of covered services, and paying the cities the full cost of delivering services at the clinics. The intent of the waivers is to shift fragmented use from costly hospital emergency rooms and outpatient departments toward lower cost MHSP clinics that would provide beneficiaries with comprehensive primary and preventive health care.

Status: MHSP waivers were scheduled to be terminated on December 31, 1984; however, HCFA agreed to extend the Medicare waivers through December 1985. With the passage of the Omnibus Budget Reconciliation Act (OBRA) of 1989, the demonstrations were extended to December 31, 1993. In addition, OBRA 1989 mandated that an independent evaluation regarding program cost-effectiveness, beneficiary costs, quality of care, and other relevant factors be undertaken and that the findings of the evaluation be submitted in a Report to Congress. HCFA contracted with Mathematica Policy Research, Inc. (MPR) to perform the independent evaluation. MPR reported that the MHSP program has grown since 1985 in terms of cost and use. The total of gross Medicare waiver services costs for the MHSP program from fiscal year (FY) 1985 to FY 1992 was $225 million. A review of the MHSP cost reports indicated that a large proportion of the increase in program costs was caused by the rise in the use of high-cost ancillary services, such as prescription drugs, dental care, and vision care. OBRA 1993 again extended the demonstration through December 31, 1997.

79-003 **Municipal Health Services Program: Cincinnati, Ohio** (Formerly, Municipal Health Services Program)

Project No.:	95-P-51000
Period:	August 1979–December 1997
Funding:	Waiver only
Award:	Service Agreement
Principal Investigator:	Malcolm P. Adcock, Ph.D.
Awardee:	City of Cincinnati 3101 Burnet Avenue Cincinnati, OH 45229
HCFA Project Officer:	Spike Duzor Office of Research and Demonstrations Support

Description: Development of the Municipal Health Services Program (MHSP) was a collaborative effort of four major cities, the U.S. Conference of Mayors, the American Medical Association, the Robert Wood Johnson Foundation (RWJF), and the Health Care Financing Administration (HCFA). It was initiated by RWJF through grants of $3 million awarded in June 1978, to each of these cities: Baltimore, Cincinnati, Milwaukee, and San Jose. HCFA joined the project by providing Medicare and Medicaid waivers to test the effects of increased use of municipal health centers by eliminating coinsurance and deductibles,

expanding the range of covered services, and paying the cities the full cost of delivering services at the clinics. The intent of the waivers is to shift fragmented use from costly hospital emergency rooms and outpatient departments toward lower cost MHSP clinics that would provide beneficiaries with comprehensive primary and preventive health care.

Status: MHSP waivers were scheduled to be terminated on December 31, 1984; however, HCFA agreed to extend the Medicare waivers through December 1985. With the passage of the Omnibus Budget Reconciliation Act (OBRA) of 1989, the demonstrations were extended to December 31, 1993. In addition, OBRA 1989 mandated that an independent evaluation regarding program cost-effectiveness, beneficiary costs, quality of care, and other relevant factors be undertaken and that the findings of the evaluation be submitted in a Report to Congress. HCFA contracted with Mathematica Policy Research, Inc. (MPR) to perform the independent evaluation. MPR reported that the MHSP program has grown since 1985 in terms of cost and use. The total gross of Medicare waiver services costs for the MHSP program from fiscal year (FY) 1985 to FY 1992 was $225 million. A review of the MHSP cost reports indicated that a large proportion of the increase in program costs was caused by the rise in the use of high-cost ancillary services, such as prescription drugs, dental care, and vision care. OBRA 1993 again extended the demonstration through December 31, 1997.

79-004 **Municipal Health Services Program: Milwaukee, Wisconsin** (Formerly, Municipal Health Services Program)

Project No.:	95-P-51000
Period:	August 1979–December 1997
Funding:	Waiver only
Award:	Service Agreement
Principal Investigator:	Samuel Akpan, Ph.D.
Awardee:	City of Milwaukee 841 North Broadway Milwaukee, WI 53202
HCFA Project Officer:	Spike Duzor Office of Research and Demonstration Support

Description: Development of the Municipal Health Services Program (MHSP) was a collaborative effort of four major cities, the U.S. Conference of Mayors, the American Medical Association, the Robert Wood Johnson Foundation (RWJF), and the Health Care Financing Administration (HCFA). It was initiated by RWJF through grants of $3 million awarded in June 1978, to each of these cities: Baltimore, Cincinnati, Milwaukee, and San Jose. HCFA joined the project by providing Medicare and Medicaid waivers to test the effects of increased use of municipal health centers by eliminating coinsurance and deductibles,

expanding the range of covered services, and paying the cities the full cost of delivering services at the clinics. The intent of the waivers is to shift fragmented use from costly hospital emergency rooms and outpatient departments toward lower cost MHSP clinics that would provide beneficiaries with comprehensive primary and preventive health care.

Status: MHSP waivers were scheduled to be terminated on December 31, 1984; however, HCFA agreed to extend the Medicare waivers through December 1985. With the passage of the Omnibus Budget Reconciliation Act (OBRA) of 1989, the demonstrations were extended to December 31, 1993. In addition, OBRA 1989 mandated that an independent evaluation regarding program cost-effectiveness, beneficiary costs, quality of care, and other relevant factors be undertaken and that the findings of the evaluation be submitted in a Report to Congress. HCFA contracted with Mathematica Policy Research, Inc. (MPR) to perform the independent evaluation. MPR reported that the MHSP program has grown since 1985 in terms of cost and use. The total gross of Medicare waiver services costs for the MHSP program from fiscal year (FY) 1985 to FY 1992 was $225 million. A review of the MHSP cost reports indicated that a large proportion of the increase in program costs was caused by the rise in the utilization of high-cost ancillary services, such as prescription drugs, dental care, and vision care. OBRA 1993 again extended the demonstration through December 31, 1997.

79-002 **Municipal Health Services Program: San Jose, California** (Formerly, Municipal Health Services Program)

Project No.:	95-P-51000
Period:	August 1979–December 1997
Funding:	Waiver only
Award:	Service Agreement
Principal Investigator:	JoAnn Foreman
Awardee:	City of San Jose 151 West Mission Street San Jose, CA 95110
HCFA Project Officer:	Spike Duzor Office of Research and Demonstrations Support

Description: Development of the Municipal Health Services Program (MHSP) was a collaborative effort of four major cities, the U.S. Conference of Mayors, the American Medical Association, the Robert Wood Johnson Foundation (RWJF), and the Health Care Financing Administration (HCFA). It was initiated by RWJF through grants of $3 million awarded in June 1978, to each of these cities: Baltimore, Cincinnati, Milwaukee, and San Jose. HCFA joined the project by providing Medicare and Medicaid waivers to test the effects of increased use of municipal health centers by eliminating coinsurance and deductibles,

expanding the range of covered services, and paying the cities the full cost of delivering services at the clinics. The intent of the waivers is to shift fragmented use from costly hospital emergency rooms and outpatient departments toward lower cost MHSP clinics that would provide beneficiaries with comprehensive primary and preventive health care.

Status: MHSP waivers were scheduled to be terminated on December 31, 1984; however, HCFA agreed to extend the Medicare waivers through December 1985. With the passage of the Omnibus Budget Reconciliation Act (OBRA) of 1989, the demonstrations were extended to December 31, 1993. In addition, OBRA 1989 mandated that an independent evaluation regarding program cost-effectiveness, beneficiary costs, quality of care, and other relevant factors be undertaken and that the findings of the evaluation be submitted in a Report to Congress. HCFA contracted with Mathematica Policy Research, Inc. (MPR) to perform the independent evaluation. MPR reported that the MHSP program has grown since 1985 in terms of cost and use. The total gross of Medicare waiver services costs for the MHSP program from fiscal year (FY) 1985 to FY 1992 was $225 million. A review of the MHSP cost reports indicated that a large proportion of the increase in program costs was caused by the rise in the use of high-cost ancillary services, such as prescription drugs, dental care, and vision care. OBRA 1993 again extended the demonstration through December 31, 1997.

95-072 On-Line ICA Program Reporting and Telecommunications System

Project No.:	97-P-08086/5-01
Period:	June 1995–June 1996
Funding:	$ 64,913
Award:	Grant
Principal Investigator:	Sara Derenge
Awardee:	Technovation Training, Inc. 3458 Brantford Road Toledo, OH 43606-2416
HCFA Project Officer:	Leslie A. Mangels Financial, Administrative, and Procurement Staff
Mandate:	Small Business Innovation Development Act of 1982 (Public Law 97-219, as amended by the Small Business Innovation Research Program, Extension, Public Law 99-443)

Description: This project will examine the feasibility of developing the following three services: (1) counseling, (2) a self-assessment instrument, and (3) related publications on quality aspects of Medicare managed care. These products/activities would provide the means for Medicare beneficiaries in the Washington, D.C., area to make informed decisions when choosing a managed care plan.

Status: Phase I (development) is currently being performed.

95-053 Patient Record System for Managing and Monitoring Health Care Delivery and Outcome

Project No.:	97-P-08134/4-01
Period:	June 1995–June 1996
Funding:	$ 50,000
Award:	Grant
Principal Investigator:	Frank Hadlock
Awardee:	Metalingual Systems, Inc. 2750 Shipley Church Rd. Cookeville, TX 38501
HCFA Project Officer:	Carl S. Hackerman Financial, Administrative, and Procurement Staff
Mandate:	Small Business Innovation Development Act of 1982 (Public Law 97-219, as amended by Public Law 99-443)

Description: This project will ultimately structure a comprehensive medical information system based on efforts to standardize computer patient records and on technology developed for credit-card-size devices.

Status: The project is in its early development phase.

95-054 Preparing Medicare Consumers for Selecting and Utilizing Managed Care Plans

Project No.:	97-P-08114/3-01
Period:	June 1995–June 1996
Funding:	$ 49,920
Award:	Grant
Principal Investigator:	Sarah Gotbaum
Awardee:	USHC Developmental Corporation 1331 H Street, NW., Suite 500 Washington, DC 20005
HCFA Project Officer:	Carl S. Hackerman Financial, Administrative, and Procurement Staff
Mandates:	Small Business Innovation Development Act of 1982 (Public Law 97-219, as amended by Public Law 99-443)

Description: The project will examine the feasibility of developing (1) counseling, (2) self-assessment instruments, and (3) related publications on quality of Medicare managed care to allow beneficiaries to make informed decisions when selecting a managed care plan.

Status: The project is in its early development phase.

95-016 Sample Design and Weighting for Medicare Risk HMO Enrollees in the Medicare Current Beneficiary Survey

Project No.:	HCFA-95-0816
Period:	September 1995–December 1995
Funding:	$ 10,000
Award:	Purchase Order
Principal Investigator:	Jim Beebe
Awardee:	Jim Beebe 1345 Tydings Road Annapolis, MD 21401
HCFA Project Officer:	Yen-Pin Chiang, Ph.D. Division of Delivery Systems and Financing

Description: The purpose of this project is to assess the sampling and weighting issues pertinent to Medicare risk health maintenance organization (HMO) enrollees included in the Medicare Current Beneficiary Survey (MCBS). The project is also to study the feasibility of and to design alternative sampling schemes specifically for Medicare risk HMO enrollees to be incorporated into future rounds of the MCBS. The original MCBS sampling frame has not taken into consideration the distribution of Medicare risk HMO enrollment across different geographic areas. This project will also study whether it is desirable or necessary to recalculate an appropriate weight to be assigned to the risk HMO members sampled in round 10 of the MCBS. The objective here is to determine whether one can obtain more accurate estimates of the characteristics of the Medicare risk HMO membership. If new sample weights are deemed desirable or necessary, the contractor will develop such new weights.

Status: This project is in the early development phase. The contractor is currently reviewing the sampling scheme employed in the MCBS.

90-023 United Mine Workers of America Demonstration

Project No.:	95-C-99643/3
Period:	July 1990–December 1995
Funding:	Waiver only
Award:	Cooperative Agreement
Principal Investigator:	Donald E. Pierce
Awardee:	UMWA Health and Retirement Funds 2021 K Street, NW. Washington, DC 20006
HCFA Project Officer:	Ronald W. Lambert Division of Delivery Systems and Financing

Description: The United Mine Workers of America (UMWA) Health and Retirement Funds (the Funds) is a waiver-only demonstration that provides a risk-based capitated payment for the Funds' Medicare-eligible retirees and dependents. The capitated payment replaces the Funds' cost-based health care prepayment plan arrangement. Approximately 82,000 Medicare eligibles are currently covered by the demonstration. This demonstration affords the Health Care Financing Administration (HCFA) the opportunity to test the ability of a large multi-employer trust to administer and contain costs under a risk-based Medicare Part B capitation arrangement.

Status: The UMWA demonstration began on July 1, 1990, and is in its sixth year of operation. The demonstration has been extended through December 31, 1995, so that HCFA can consider the Funds' proposal for a new demonstration to include Part A. The Part B capitation rate was rebased for the period July 1994 through June 1995. This rate was updated according to the increase in the U.S. per capita cost index for the period July 1995 through December 1995.

94-020 Use of Health Status Measures from the Medicare Current Beneficiary Survey to Improve the Adjusted Average Per Capita Cost

Project No.:	HCFA-94-0808
Period:	July 1994–June 1995
Funding:	$ 25,000
Award:	Contract
Principal Investigator:	Leonard Gruenberg, Ph.D.
Awardee:	DataChron Health Systems 763 Massachusetts Avenue, Suite 7 Boston, MA 02139
HCFA Project Officer:	Renee Mentnech Division of Health Information and Outcomes

Description: The purpose of this project is to use the health status measures from the Medicare Current Beneficiary Survey to improve the adjusted average per capita cost (AAPCC) method of paying health maintenance organizations. Various health status adjusters will be compared. Both the combined and independent effects on future use and expenditures of self-reported health status, disability status, diagnostic cost group category, and the AAPCC factors will be examined.

Status: The analyses have been completed. A draft final report was submitted and reviewed. Reviewer comments were sent to the contractor for incorporation into the final report. The final report incorporating reviewer comments has not been received.

95-082 **Wide Area Networking of Computerized Patient Records**

Project No.:	97-P-08099/9-01
Period:	June 1995–June 1996
Funding:	$ 50,000
Award:	Grant
Principal Investigator:	Bruce S. Orisek
Awardee:	MIS, Inc. Dominican Professional Building 1505 Soquel Drive Santa Cruz, CA 95065
HCFA Project Officer:	Cheryl Sample Financial, Administrative, and Procurement Staff
Mandates:	Small Business Innovative Development Act of 1982 (Public Law 97-219; as amended by the Small Business Innovation Research Program, Extension, Public Law 99-443)

Description: The major objective of this project is the further development and clinical trial of computer-based patient records within a wide area network called MIS/Work Comp System, a product that will diminish and, in many cases, negate the need for utilization review.

Status: The grantee is currently working on Phase I, the development phase of the project.

Intramural

IM-050 **Disenrollment of Medicare Cancer Patients from HMOs**

Funding:	Intramural
HCFA Project Director:	Gerald F. Riley, James D. Lubitz Division of Health Information and Outcomes

Description: There is concern that financial incentives in health maintenance organizations (HMOs) might result in pressures to induce sicker members to disenroll. The study compared disenrollment rates of Medicare HMO enrollees with cancer to disenrollment rates for cancer-free enrollees, using Medicare enrollment files linked to population-based tumor registry data from the Surveillance, Epidemiology, and End Results (SEER) program.

The study identified all aged Medicare beneficiaries who enrolled in an HMO in a SEER reporting area during 1985–1989. Time from enrollment to disenrollment was analyzed by using a Cox proportional hazards model. The analysis controlled for age, sex, race, and Medicaid status. Enrollees were followed for up to 18 months after a diagnosis of cancer.

Status: The results have been submitted for publication and are under review.

IM-037 **Medicare HMO Evaluation**

Funding:	Intramural
HCFA Project Directors:	Cynthia G. Tudor, Ph.D., Mel Ingber, Ph.D., Yen-Pin Chiang, Ph.D., and Gerald F. Riley Division of Delivery Systems and Financing

Description: This evaluation attempts to update the findings from an earlier study of the Medicare risk health maintenance organization (HMO) program, conducted by Mathematica Policy Research, Inc. That study found that the Health Care Financing Administration paid 5.7 percent more for HMO enrollees than would have been spent on them under fee-for-service (FFS).

The current study has four components: disenrollment from HMOs, beneficiary satisfaction, quality of care, and selection and savings. The disenrollment analysis will examine differences between HMO enrollees and disenrollees. The beneficiary satisfaction analysis will examine differences in satisfaction with care between HMO enrollees and beneficiaries in the FFS sector. The quality of care analysis will examine differences in the outcomes of care for HMO enrollees and for beneficiaries in the FFS sector. The selection and savings analysis will determine whether HMO enrollees differ systematically from those beneficiaries who remain in FFS. If HMOs are experiencing favorable selection, then payments for healthier enrollees should reflect these differences.

Status: Analyses are under way. Draft findings are expected to be available in early 1996.

IM-051 **Stage of Cancer at Diagnosis for Medicare HMO and Fee-for-Service Enrollees**

Funding:	Intramural
HCFA Project Director:	Gerald F. Riley, James D. Lubitz Division of Health Information and Outcomes

Description: The study examined stage of cancer at diagnosis for aged Medicare enrollees in health maintenance organizations (HMOs) and fee-for-service, using information from the Surveillance, Epidemiology, and End

Results program, linked with Medicare enrollment files. Twelve cancer sites were investigated, and demographics, area of residence, year of diagnosis (1985–89), and education at the census tract level were controlled.

HMO enrollees were diagnosed at earlier stages for cancers of the female breast, cervix, colon, and for melanomas, and at later stages for stomach cancer. There were no differences for cancers of the prostate, rectum, buccal cavity and pharynx, bladder, uterus, kidney, and ovary. HMO effects were strongest in areas with large, mature HMOs. The earlier detection of certain cancers among HMO enrollees may result from coverage of screening services and, perhaps, promotion by HMOs of such services.

Status: The study has been published under the following citation: Riley, G.F., Potosky, A.L., Lubitz, J.D., and Brown, M.L.: "Stage of Cancer at Diagnosis for Medicare HMO and Fee-for-Service Enrollees," *American Journal of Public Health,* 84:1598-1604, 1995.

Extramural

94-002 Assessment and Redesign of Medicare Fee Schedule Areas (Localities)

Project No.:	500-92-0020DO09
Period:	July 1994–October 1995
Funding:	$ 125,882
Award:	Delivery Order in Master Contract
Principal Investigator:	Gregory C. Pope, Ph.D.
Awardee:	Health Economics Research, Inc. (See page 206)
HCFA Project Officer:	Sherry A. Terrell, Ph.D. Division of Payment Systems

Description: The purpose of this delivery order is to reassess the 210 (as of January 1995) Medicare Part B pricing locality areas to determine the feasibility of using some other geographic configuration such as States, Metropolitan Statistical Areas (MSAs), or county groupings as Medicare fee schedule areas (MFSAs). Currently, there is no standard geographic definition of a Medicare payment locality. In 22 States, the entire State is a single payment locality. In the remaining 28 States, there are multiple localities, ranging from 32 in Texas to 2 localities in Idaho, Massachusetts, Michigan, and Mississippi. Localities were established by Medicare fiscal agents, known as carriers, to reflect local differences in medical practice and economic conditions. Once established, localities could not be changed without reason. Consequently, except for several consolidations, usually to a State locality, Medicare physician payment boundaries have remained relatively stable since the inception of the program in 1966. The Health Care Financing Administration intends to reassess the current multistate MFSAs since some of the distinctions that dictated the original locality definitions may no longer be meaningful.

Status: This project is near completion. A draft final report in two volumes has been received. The final report, *Assessment and Redesign of Medicare Fee Schedule Areas (Localities), Vol. I: Text and Tables and Vol. II: Maps*, will be available from the National Technical Information Service. Four options were evaluated as alternatives to the current MFSAs based on the percentage differences between the 1996 Geographic Adjustment Factor (GAF) and that for each option using a range of thresholds to simulate changes in the GAF as compared to current locality configurations. Option 1 is based on MFSAs as the building block, Option 2 is based on MSAs, Option 3 is based on metropolitan area populations classes within States, and Option 4 uses metropolitan population classes to define five areas nationally. The study also addresses the problem of sub-county localities.

92-030 Bundling Physician Services

Project No.:	500-89-0050
Period:	March 1992–December 1995
Funding:	$ 354,418
Award:	Contract
Principal Investigator:	A. James Lee, Ph.D.
Awardee:	Health Economics Research, Inc. 300 Fifth Avenue, 6th Floor Waltham, MA 02154
HCFA Project Officer:	Teresa L. DeCaro Division of Payment Systems

Description: The purpose of this project is to develop and evaluate innovative alternatives to packaging ancillary services with physician office-based visits. It involves five discrete tasks including assessing the reliability of diagnostic coding and Unique Physician Identification Numbers (UPINs) in the 1992 Part B National Claims History data; developing a criteria paper to guide the development and evaluation of alternative bundling strategies; conducting descriptive analyses of various ancillary bundles; exploring the application of ambulatory patient group (APG) assignment and weighing algorithms to physician services provided in an office setting; and simulating redistributive impacts of various bundling strategies.

Status: Three early reports include "An Exploratory Investigation of UPIN and Diagnostic Reporting in the National Claims History"; "Descriptive Analysis of Ancillary Service Bundles "; and "Criteria Paper: Issues in Visit-Based Bundling." The criteria paper is available from the National Technical Information Service, accession number PB93-184158. It explores equity-efficiency tradeoffs using various examples of bundles that conceptually make up a packaging continuum. Design issues are discussed, and evaluation criteria are developed, including cost reduction potential, redistributive consequences, potential for inappropriate responses, and administrative feasibility. It presents four ancillary bundling models, all targeting high-volume, low-cost ancillaries. These models were built and analyzed using a 5-percent sample of 1992 national claims history data. Ancillaries were attributed to visits using a hierarchical matching

algorithm involving UPIN numbers, diagnosis codes, and 7-day pre- and post- windows. Seventy seven percent of ancillaries were attributed to office visits using these rules. Only one model—the common diagnosis model—demonstrated significant, practical potential for future payment. In this model diagnosis groups are formed using clinical input. Visits are classified according to CPT-4 definitions and then subdivided by diagnosis group using the diagnosis on the visit claim. Ancillaries are then attributed to each visit according to the hierarchical method. For each subdivided visit type, the average utilization of high-volume, low-cost ancillaries is measured and transposed into an adjustment weight that increases the visit relative value unit. Finally, bundled payment of ancillaries into visits using the adjustment weights is simulated to measure the distribution impacts by geographic region and physician specialty. Only 5 specialties, accounting for 5 percent of visits, gain 2 percent or more. Two specialties, accounting for 1 percent of visits, lose 2 percent or more. Distributional impacts are significantly larger across geographic regions.

Administrative issues of visit-based ancillary bundling are explored, as are the necessary analytic steps to complete the development of this payment model. The APG task is in progress and a separate report will be generated in December 1995.

90-005 Changes in Hospital Wages Since Implementation of the Prospective Payment System

Project No.:	17-C-99500/1
Period:	October 1989–October 1993
Funding:	$ 212,478
Award:	Cooperative Agreement
Principal Investigator:	Gregory C. Pope, Ph.D.
Awardee:	Health Economics Research, Inc. Hillsite Office Building 75 Second Avenue, Suite 100 Needham, MA 02194
HCFA Project Officer:	Edgar A. Peden, Ph.D. Division of Payment Systems
Mandate:	Social Security Amendments of 1983 (Public Law 98-21)

Description: In this project, Health Economics Research, Inc., researchers examine the determinants of hospital wages using the Health Care Financing Administration's (HCFA's) surveys from 1982, 1984, and 1988; the American Hospital Association's (AHA) annual surveys; and the Bureau of Labor Statistics' (BLS) industry wage surveys. Labor costs account for more than one-half of all hospital costs. For individual hospitals, these costs are affected by hospital occupation mix, wages earned in alternative employment (opportunity wages), labor productivity, inpatient volumes, and the cost of living. Using regression analysis, this project investigates empirically the linkages of these factors to labor costs.

Status: The awardee reviewed the literature on hospital and firm wage determination, constructed a model of wage determination, and made estimates of the model based on data received from HCFA, the BLS, and the AHA. This study finds that the major determinants of hospital average hourly compensation are area opportunity wages (i.e., the amount hospital workers could earn in alternative occupations in an area); area hospital-specific opportunity wages; hospital size; hospital case mix; hospital occupation mix; hospital unionization; and the competitiveness of the area labor market. Opportunity wages have by far the largest effect on hospital wages. Nevertheless, the other factors, especially taken as a group, have a significant impact on wages. Together, the above seven variables explain about 70 percent of the variation in hospital wages. Health Economics Research, Inc., researchers suggest various policy changes that HCFA might make in paying the wage portion of costs under the prospective payment system. These include refining the wage survey instrument, using wage data from the decennial census, and statistically removing the effects of various factors on the wage index. The final report, "Hospital Wages and the Prospective Payment System," accession number PB94-207560, is available from the National Technical Information Service.

94-008 Collect Malpractice Insurance Premium Rate Information

Project No.:	500-94-0039
Period:	July 1994–June 1997
Funding:	$ 347,892
Award:	Contract
Principal Investigator:	Karen Reilly, Sc.D.
Awardee:	Allied Technology Group, Inc. 1803 Research Boulevard, Suite 601 Rockville, MD 20850
HCFA Project Officer:	Benson L. Dutton Division of Payment Systems

Description: This study surveys State insurance commissioners, physician-owned malpractice insurers, physician associations, cooperatives, and physician joint underwriting associations. Premium rate data will be obtained from State insurance departments. These data will be used by the Health Care Financing Administration (HCFA) staff and outside contractors to update the malpractice component of the Medicare Economic Index (MEI) and to refine the malpractice component of the

geographic practice cost index (GPCI) for the Medicare fee schedule (MFS). By law, HCFA is required to compute the annual rate of increase in malpractice insurance costs for use in the MEI and to periodically review and update the GPCI. Section 1848(e) of the Omnibus Budget Reconciliation Act (OBRA) of 1989 (Public Law 101-239) and section 4118 of OBRA 1990 (Public Law 101-508) require the Secretary of Health and Human Services to develop and update geographic adjustment factors for existing payment localities used in calculating the MFS. Second year tasks include developing methods for collecting representative premium data for the national MEI estimates and the GPCI market areas; investigating possible expansion to the survey; determining the existence, composition, and authority of any State patient compensation funds and joint underwriting associations; and linking the 1993-95 premium data collected under this survey with the 1989-92 data collected previously.

Status: The first deliverable under this project was a research design/analysis plan. Other tasks completed in the first year included: interviewing State insurance commissioners' staff to identify physician medical liability insurance companies in the State; collecting $1 million/$3 million malpractice premium rates for policies for 1993-95 from State insurance commissioners' office files, if available, and otherwise, through contacting key insurance company personnel named by the State insurance office; and identifying any sub-State coverage and pricing areas.

95-014 Data Collection and Analysis for Generating Procedure Specific Practice Expense Estimates

Project No.:	500-95-0009
Period:	March 1995–November 1996
Funding:	$ 2,603,065
Award:	Contract
Principal Investigator:	Monica Noether, Ph.D.
Awardee:	Abt Associates, Inc. 55 Wheeler Street Cambridge, MA 02138
HCFA Project Officer:	Jesse M. Levy, Ph.D. Division of Payment Systems
Mandate:	1994 Amendments to the Social Security Act (Public Law 103–105, Section 221)

Description: Under the original mandating legislation for the Medicare Fee Schedule, the relative values for practice expenses are based on historical charges. This method has been widely criticized for not being based on the costs of providing services. This study will collect data that will be used to derive resource-based relative values for practice expenses. The project will comprise multiple sources of data, including a practice-level practice expense survey and standardized input cost data. Panels of clinicians will also be used to enumerate practice inputs for a limited number of physician services.

Status: Work on this project is in the early stages.

92-007 Data for Hospital Cost Monitoring and Analysis of Hospital Costs

Project No.:	500-92-0003
Period:	January 1992–December 1996
Funding:	$ 715,700
Award:	Contract
Awardee:	American Hospital Association 840 North Lake Shore Drive Chicago, IL 60611
HCFA Project Officer:	Benson L. Dutton Division of Payment Systems
Mandate:	1983 Amendment to the Social Security Act (Public Law 98-21)

Description: The American Hospital Association (AHA) collects data on hospitals with (a) the Annual Survey of Hospitals and (b) the National Monthly Hospital Panel Survey. The annual survey of hospitals data base consists of the following files: the AHA Annual Survey Expanded Data file; the modified Federal Information Processing System (FIPS) county codes and names file; the full FIPS county codes and names file; Metropolitan Statistical Area codes and names file; the data file layout file; the COBOL data file description; the SAS data file description; the health care system layout file; and the health care system data file. The monthly hospital panel survey collects information on: hospital beds and bassinets; inpatient and outpatient utilization; revenue, expenses and current assets and liabilities; personnel; and utilization for inpatients 65 years old and older. The national hospital panel output data along with other documentation are delivered quarterly as data cartridge tapes, micro-floppy disks and printed tables. The annual survey of hospitals data are delivered annually in December for the preceding year in the data cartridge tape format only.

Status: The monthly National Hospital Panel Survey Reports and the monthly Hospital Statistics through March 1995 have been delivered. The Annual Survey of Hospitals for fiscal year 1994 is expected in December 1995.

94-097 Demonstration of Managed Care under Medicare Using Volume Performance Standards Organizations

Project No.:	95-C-90388/1
Period:	September 1994–March 1998
Funding:	$ 350,000
Award:	Cooperative Agreement
Principal Investigator:	Christopher P. Tompkins, Ph.D.
Awardee:	Brandeis University Heller Graduate School Institute for Health Policy 415 South Street P.O. Box 9110 Waltham, MA 02254-9110
HCFA Project Officer:	Teresa L. DeCaro Division of Payment Systems
Mandate:	Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239)

Description: The purpose of this project is to demonstrate the physician group volume performance standard (GVPS) model which creates a risk sharing arrangement between participating physician-sponsored groups and the Health Care Financing Administration under the fee-for-service (FFS) program. To participate the group would have to meet quality and other standards, and submit case management and other clinical strategies to improve the disease management and coordination of care for selected types of high-cost patients. Each group would operate under FFS. At the end of each year the group's actual case-mix adjusted performance would be compared to its per capita target, based on the group's historical experience. While the target would be based on all Medicare reimbursements per unique patient seen (RPUPS) by the group, the sharing formula for Medicare savings would be constrained by the percent of total services actually provided by the group. This percentage is called the patient capture ratio (PCR). Groups would be provided with profiles of their utilization to assist in meeting their targets in a clinically cogent manner. The demonstration will include several nationally recognized physician group practices. The goals of this demonstration include the following:

- Testing whether selected physician organizations can improve the efficiency and delivery of services to Medicare beneficiaries in the fee-for-service sector.
- Testing and refining reimbursement and incentive systems that reward providers for delivering care efficiently.
- Developing new techniques for using information for organizational and clinical decision-making (profiling) to facilitate controlling costs without sacrificing quality or access to care.
- Targeting GVPS models at selected physician group practices that could represent "best practices" and provide clinical and managerial leadership toward the objective of improved efficiency in the fee-for-service market.
- Developing and testing the feasibility of the required administrative infrastructure.

This demonstration follows research and development of the GVPS model under two prior studies (99-C-98526/1 and 17-C-90129/1). These studies and this demonstration respond to legislation enacted along with the implementation of the national Medicare volume performance standard (MVPS) in the Omnibus Budget Reconciliation Act of 1989 (Section 6102a). The legislation specifies that the Secretary shall implement a plan under which qualified physician groups can elect annually separate performance standard rates of increase other than the national standard established for the year.

Status: The demonstration design is due in end of year 1995. Sites will be selected from among 10 that offered to participate under the cooperative agreement. The demonstration is expected to last 3 years and begin in early 1996.

95-012 Derivation of Relative Values for Practice Expenses Using Extant Data

Project No.:	500-92-0020DO10
Period:	April 1995–March 1996
Funding:	$ 82,796
Award:	Delivery Order in Master Contract
Principal Investigator:	Gregory C. Pope
Awardee:	Health Economics Research, Inc. (See page 206)
HCFA Project Officer:	Jesse M. Levy, Ph.D. Division of Payment Systems

Description: Under the original mandating legislation for the Medicare Fee Schedule, the relative values for practice expenses are based on historical charges. This method has been widely criticized for not being based on the costs of providing services. This study is an attempt to speedily derive relative values for practice expenses that are more resource-based than the existing methods. No new data collection will be performed under this project. Under this study, relative values are derived as a mark-up to the relative values for work.

Status: Work on this project is proceeding as scheduled.

95-013 **Derivation of Relative Values for Practice Expenses Using Extant Data**

Project No.:	500-92-0023DO10
Period:	May 1995–March 1996
Funding:	$ 61,075
Award:	Delivery Order from Master Contract
Principal Investigator:	Daniel Dunn, Ph.D.
Awardee:	The RAND Corporation
	(See page 208)
HCFA Project Officer:	Jesse M. Levy, Ph.D. Division of Payment Systems

Description: Under the original mandating legislation for the Medicare Fee Schedule, the relative values for practice expenses are based on historical charges. This method has been widely criticized for not being based on the costs of providing services. This study is an attempt to speedily derive relative values for practice expenses that are more resource-based than the existing methods. No new data collection will be performed under this project. Under this study, relative values are derived as a function of time.

Status: Work on this project is proceeding as scheduled.

91-073 **Design and Evaluation of a Prospective Payment System for Ambulatory Care**

Project No.:	17-C-90057/5
Period:	September 1991–March 31, 1995
Funding:	$ 950,849
Award:	Cooperative Agreement
Principal Investigator:	Richard Averill
Awardee:	3M-Health Information Systems 100 Barnes Road Wallingford, CT 06492
HCFA Project Officer:	Joseph M. Cramer Division of Payment Systems
Mandate:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509)

Description: In 1989, the Health Care Financing Administration awarded 3M-Health Information Systems (3M-HIS) a 2-year grant to develop a patient classification system that could be used as the basis of payment for an outpatient prospective payment system (PPS) for Medicare. 3M-HIS finished development of a complete set of ambulatory patient groups (APG) along with a set of payment weights and prepared a final report. The purpose of this project is to update the prior work done on APGs using a new data base. The project addresses a broad range of issues including care in the emergency room, determination of payment for outliers, and incorporation of a review of all the basic components on an APG-based PPS. The research consists of three phases:

- Phase I. Update the existing APG classification scheme.
- Phase II. Evaluate APGs using a new database, make necessary modifications, compute APG payment weights, and simulate an APG-based payment system.
- Phase III. Propose and test a revision of parts of the *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD-9-CM) diagnosis codes.

Status: 3M-HIS completed development of Version 2.0 of the APGs and issued the grouper software and definitions manual. Both are also available from the awardee. The data for Phase III has been analyzed and the final report for the APG project is being written. 3M-HIS has also developed the models for the APG payment simulations.

90-068 **Determining the Appropriateness of Reclassifying a Ventilator-Dependent Unit as a Rehabilitation Unit for Purposes of Reimbursement: Illinois** (Formerly, Determining the Appropriateness of Reclassifying a Ventilator-Dependent Unit as a Rehabilitation Unit for Purposes of Reimbursement)

Project No.:	29-P-99397/5
Period:	October 1989–May 1995
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Cheryl Morris
Awardee:	RMS Health Providers Joint Venture of Suburban Hospital/Rush Presbyterian Hospital Hinsdale, IL 60521
HCFA Project Officer:	Michael Henesch Division of Payment Systems
Mandate:	Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360)

Description: Four sites have implemented the demonstration: Mayo Foundation in Rochester, Minnesota; RMS Health Providers in Chicago, Illinois; Sinai Hospital in Detroit, Michigan; and Temple University Hospital in Philadelphia, Pennsylvania. The demonstration will be used to determine the appropriateness of reclassifying ventilator-dependent hospital components as rehabilitation units for purposes of Medicare reimbursement. The demonstration is for a period of 3 years corresponding to each site's fiscal year. Start dates ranged from July 1, 1991, to

July 1, 1992. Standard admission criteria for use across the sites were developed in cooperation with the demonstration sites and are used by the professional review organization to evaluate admissions and discharges. An empirical analysis will be conducted to compare the cost of the services, quality of care, and patient outcomes for demonstration patients to patients in a control group. The analysis also will examine the demonstration sites, as well as alternative care settings in the private sector, to evaluate the effect of modifications in reimbursement policy shifting from a prospective payment system for these units to the Tax Equity and Fiscal Responsibility Act method of reimbursement. Based on the results of the evaluation, the Health Care Financing Administration will be able to determine the appropriate policy for paying for the hospital care of chronic ventilator patients. This site concluded operating under the demonstration on May 31, 1995.

Status: Data are being collected and analyzed, in preparation of the final report expected in February 1996.

90-069 **Determining the Appropriateness of Reclassifying a Ventilator-Dependent Unit as a Rehabilitation Unit for Purposes of Reimbursement: Michigan** (Formerly, Determining the Appropriateness of Reclassifying a Ventilator-Dependent Unit as a Rehabilitation Unit for Purposes of Reimbursement)

Project No.:	29-P-99408/3
Period:	October 1989–June 1995
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Diane Czlonka
Awardee:	Sinai Hospital of Detroit Detroit, MI 48235
HCFA Project Officer:	Michael Henesch Division of Payment Systems
Mandate:	Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360)

Description: Four sites have implemented the demonstration: Mayo Foundation in Rochester, Minnesota; RMS Health Providers in Chicago, Illinois; Sinai Hospital in Detroit, Michigan; and Temple University Hospital in Philadelphia, Pennsylvania. The demonstration will be used to determine the appropriateness of reclassifying ventilator-dependent hospital components as rehabilitation units for purposes of Medicare reimbursement. The demonstration is for a period of 3 years corresponding to each site's fiscal year. Start dates ranged from July 1, 1991, to July 1, 1992. Standard admission criteria for use across the sites were developed in cooperation with the demonstration sites and are used by the professional review organization to evaluate admissions and discharges. An empirical analysis will be conducted to compare the cost of the services, quality of care, and patient outcomes for demonstration patients to patients in a control group. The analysis also will examine the demonstration sites, as well as alternative care settings in the private sector, to evaluate the effect of modifications in reimbursement policy shifting from a prospective payment system for these units to the Tax Equity and Fiscal Responsibility Act method of reimbursement. Based on the results of the evaluation, the Health Care Financing Administration will be able to determine the appropriate policy for paying for the hospital care of chronic ventilator patients. This site concluded operating under terms of the demonstration on June 30, 1996.

Status: Data are being collected at each site, in preparation of the final report expected in February 1996.

90-067 **Determining the Appropriateness of Reclassifying a Ventilator-Dependent Unit as a Rehabilitation Unit for Purposes of Reimbursement: Minnesota** (Formerly, Determining the Appropriateness of Reclassifying a Ventilator-Dependent Unit as a Rehabilitation Unit for Purposes of Reimbursement)

Project No.:	29-P-99424/5
Period:	October 1989–December 1994
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Douglas R. Gracey, M.D.
Awardee:	Mayo Foundation St. Mary's Hospital Rochester, MN 55905
HCFA Project Officer:	Michael Henesch Division of Payment Systems
Mandate:	Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360)

Description: Four sites have implemented the demonstration: Mayo Foundation in Rochester, Minnesota; RMS Health Providers in Chicago, Illinois; Sinai Hospital in Detroit, Michigan; and Temple University Hospital in Philadelphia, Pennsylvania. The demonstration will be used to determine the appropriateness of reclassifying ventilator-dependent hospital components as rehabilitation units for purposes of Medicare reimbursement. The demonstration is for a period of 3 years corresponding to each site's fiscal year. Start dates ranged from July 1, 1991, to July 1, 1992. Standard admission criteria for use across the sites were developed in cooperation with the demonstration sites and are used by the professional review organization to evaluate admissions and discharges. An empirical analysis will be conducted to compare the cost of the services,

quality of care, and patient outcomes for demonstration patients to patients in a control group. The analysis also will examine the demonstration sites, as well as alternative care settings in the private sector, to evaluate the effect of modifications in reimbursement policy shifting from a prospective payment system for these units to the Tax Equity and Fiscal Responsibility Act method of reimbursement. Based on the results of the evaluation, the Health Care Financing Administration will be able to determine the appropriate policy for paying for the hospital care of chronic ventilator patients. This site concluded operating under the demonstration on December 31, 1994.

Status: Data are being collected and analyzed from each site, in preparation of the final report expected in February 1996.

90-070 **Determining the Appropriateness of Reclassifying a Ventilator-Dependent Unit as a Rehabilitation Unit for Purposes of Reimbursement: Pennsylvania** (Formerly, Determining the Appropriateness of Reclassifying a Ventilator-Dependent Unit as a Rehabilitation Unit for Purposes of Reimbursement)

Project No.:	29-P-99401/3
Period:	October 1989–June 1994
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Gerard J. Criner, M.D.
Awardee:	Temple University Hospital Philadelphia, PA 19140
HCFA Project Officer:	Michael Henesch Division of Payment Systems
Mandate:	Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360)

Description: Four sites have implemented the demonstration: Mayo Foundation in Rochester, Minnesota; RMS Health Providers in Chicago, Illinois; Sinai Hospital in Detroit, Michigan; and Temple University Hospital in Philadelphia, Pennsylvania. The demonstration will be used to determine the appropriateness of reclassifying ventilator-dependent hospital components as rehabilitation units for purposes of Medicare reimbursement. The demonstration is for a period of 3 years corresponding to each site's fiscal year. Start dates ranged from July 1, 1991, to July 1, 1992. Standard admission criteria for use across the sites were developed in cooperation with the demonstration sites and are used by the professional review organization to evaluate admissions and discharges. An empirical analysis will be conducted to compare the cost of the services, quality of care, and patient outcomes for demonstration patients to patients in a control group. The analysis also will examine the demonstration sites, as well as alternative care settings in the private sector, to evaluate the effect of modifications in reimbursement policy shifting from a prospective payment system for these units to the Tax Equity and Fiscal Responsibility Act (TEFRA) method of reimbursement. Based on the results of the evaluation, the Health Care Financing Administration will be able to determine the appropriate policy for paying for the hospital care of chronic ventilator patients. This site concluded operating under the demonstration on June 30, 1994.

Status: Data are being collected at each site, in preparation of the final report which is expected in February 1996. This site has requested a continuation of the demonstration for an additional 3 years retroactively from July 1, 1994. The continuation is requested to allow the site the time to integrate the ventilator unit into the hospital's skilled nursing facility. This will permit them to continue receiving reimbursement under TEFRA reimbursement principles. This request is being reviewed.

91-075 **Developing Cost Control Policies for Medicare Outpatient Services**

Project No.:	17-C-90036/3
Period:	September 1991–September 1996
Funding:	$ 385,092
Award:	Cooperative Agreement
Principal Investigator:	Margaret Sulvetta
Awardee:	The Urban Institute 2100 M Street, NW. Washington, DC 20037
HCFA Project Officer:	Mark A. Krause, Ph.D. Division of Payment Systems
Mandate:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509)

Description: The objective of this project is to provide the Health Care Financing Administration with information to design cost control policies for care delivered in hospital outpatient departments. In particular, the information will be useful in the development of a prospective payment system for such services. The study principally addresses these questions:

- What are the average costs and the group variation of costs defining the units of service to bundle different ranges of ancillary services?
- What are the technical implications of bundling payment for physicians' services with those of facility payment?
- What affiliation patterns do physicians have with hospitals and is physicians' work concentrated among very few facilities?

- What proportion of the growth in outpatient expenditures is attributable to general inflation, service-specific inflation, increases in visits, increases in services per visit, or to a shift in the types of services?
- How do charges, Medicare calculated costs, and resource costs (from the Center for Health Policy Studies' analysis) compare absolutely and relatively?

Status: The Urban Institute was awarded a 12-month competing continuation to complete a descriptive and a hospital impact analysis of the Ambulatory Patient Group (APG) Version 2.0 prospective payment system developed by 3M-Health Information Systems (3M-HIS). The data to be used in this analysis is a representative beneficiary sample stratified by the size of the facility and whether the reason for the visit was procedural, medical, or ancillary only. The data file will consist of 1993 beneficiary claims. The descriptive statistical analysis will identify any atypical volume, cost or charge APG. An examination of the coefficient of variation (CV) statistic will provide information regarding the grouping of unlike procedures and the impact of ancillary packaging on APG average charges and costs. Facility level case-mix indices (CMIs) will be calculated for various hospital types (size, urban/rural, teaching etc.).

The impact analysis will consist of a simulation of what types of facilities may gain or lose under APGs paid on an average-cost basis and what is the magnitude of the gain or loss. Urban will utilize the 1993 OPD payment methodology by type of facility and compare that to the payments under the APG grouping methodology.

94-111 Development of a Physician Prospective Payment System for Ambulatory Care

Project No.:	17-C-90309/5
Period:	September 1994–March 1996
Funding:	$ 421,451
Award:	Cooperative Agreement
Principal Investigator:	Merritt R. Marquardt
Awardee:	Minnesota Mining and Manufacturing Company Health Information Systems St. Paul, MN 55144-1000
HCFA Project Officer:	Mark A. Krause, Ph.D. Division of Payment Systems

Description: The objective of this project is to develop for the Health Care Financing Administration a new patient classification system that can be used as a basis for a prospective payment system (PPS) for physician services. This new patient classification system will be based on a previously developed patient classification system for the facility component of outpatient services constructed by 3M-Health Information Systems. This system called ambulatory patient groups (APGs) has been in existence since 1990 and is being employed as a payment methodology by several payers. This physician PPS analysis will augment the APGs to encompass the professional as well as the facility component of ambulatory care. The classification methodology will be called physician care groups (PCGs). The development of PCGs will be based on a comprehensive analysis of the Medicare physician payment database as well as on other non-Medicare databases. The completion of this research will provide an alternative classification system for the payment of physicians that, in combination with the APGs, may provide a coordinated basis for the implementation of a PPS for both the professional and facility costs of ambulatory care.

Status: The project is in the early development stage.

94-017 Evaluating Methods of Estimating Hospital Efficiency

Project No.:	500-93-0029DO02
Period:	December 1993–September 1995
Funding:	$ 296,575
Award:	Delivery Order in Master Contract
Principal Investigator:	Robert J. Schmitz, Ph.D.
Awardee:	Abt Associates, Inc. (See page 206)
HCFA Project Officer:	William L. England, Ph.D., J.D. Division of Health Information and Outcomes

Description: This project is performing data envelopment analysis (DEA) using IDEAS software, and stochastic frontier analysis (SFA) using LIMDEP, Version 6 software, to assess the process by which hospitals provide patient care "output" as a function of input prices, in an effort to measure the elusive concept of hospital efficiency and quality of care. These methods assume that "similar" hospitals should produce equivalent patient care at similar costs and the extent to which they differ is a measure of inefficiency. The definition of "similar" is critical to the analysis, and Phase I of this project reviewed the literature on DEA and SFA to determine what variables (e.g., size, case mix, teaching status, local wage level) should be used to adjust for differences among hospitals. In Phase II, a computer simulation model was developed to generate data from a known model of hospital cost and efficiency. This model was used to assess the ability of DEA and SFA to estimate the true efficient frontier, and to measure the cost of inefficiency, by "endowing" the model with given degrees of inefficiency. The model was also used to assess the validity and robustness of DEA and SFA to random noise, measurement error, and missing data. Data for the model include institution-specific employment data from the American Hospital Association; data from the Health Care Financing Administration's (HCFA's) Hospital Cost Report

Information System; Census data; State-specific files, including data from the California Office of Statewide Health Planning and Development and the Pennsylvania Medical data base; and data on individual stays for Medicare beneficiaries from HCFA's Medicare provider analysis and review data base.

Status: The final report is currently under review.

95-004 Evaluation of Case Classification Systems and Design of a Prospective Payment Model for Inpatient Rehabilitation

Project No.:	500-92-0023
Period:	September 1995–August 1996
Funding:	$ 453,847
Award:	Cooperative Agreement
Principal Investigators:	Grace M. Carter, Ph.D. and Joan Buchanan, Ph.D.
Awardee:	The RAND Corporation (See page 208)
HCFA Project Officer:	William Buczko, Ph.D. Division of Payment Systems

Description: This project will evaluate the utility of functional assessment measures and the appropriateness of a patient classification system developed by the University of Pennsylvania Medical school for reimbursement of Medicare inpatient rehabilitation. Based on this evaluation, the contractor will construct a model of a prospective reimbursement system for inpatient rehabilitation under Medicare.

Status: Project activity is in the startup phase. Technical evaluation panels for evaluation of functional assessment measures and patient classification systems will meet in late 1995/early 1996. Data analysis will begin in late 1995.

95-060 Evaluation of the Iowa Implementation of Ambulatory Patient Groups (APGs)

Project No.:	500-92-0047
Period:	April 1995–April 1997
Award:	Contract
Funding:	$ 322,218
Principal Investigator:	George Wright
Awardee:	Mathematica Policy Research, Inc. (See page 205)
HCFA Project Officer:	Joseph M. Cramer Division of Payment Systems

Description: Under this contract, Mathematica will design and implement an evaluation of the Iowa Medicaid Program outpatient prospective payment system. Iowa will use the APG system developed by 3M-Health Information Systems. The focus of the task will be to perform a preliminary evaluation of the APG system, using data collected from the facilities and the State. In addition, Mathematica will describe the implementation of APGs in two Blue Cross/ Blue Shield plans in Ohio and California. The evaluation activities to be conducted by the contractor will consist of a case study of Iowa's development and implementation of the APG system followed by an analysis of the project's reimbursement methodology. The purpose of the analysis is to assess the application of the APG system for potential implementation by Medicare on a national basis.

Status: The contractor is working on the evaluation design report.

90-012 Evaluation of the Ventilator-Dependent Unit Demonstration

Project No.:	500-87-0029TO05
Period:	October 1989–February 1996
Funding:	$ 1,034,030
Award:	Technical Support: Evaluation of Demonstrations
Principal Investigator:	Theresa Mullin, Ph.D.
Awardee:	Lewin/VHI, Inc. 9300 Lee Highway, Suite 400 Fairfax, VA 22031-1207
HCFA Project Officer:	Michael Henesch Division of Payment Systems
Mandate:	Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360)

Description: Treating ventilator-dependent patients in hospitals is labor intensive, and the cost of the service for patients who are being weaned often exceeds the present-day payment system under prospective payment. The awardee will evaluate four competitively selected demonstration sites that provide care for chronic ventilator-dependent patients. The evaluation comprises three major components: case studies of the demonstration sites, including a comparison of Medicare reimbursement for patient care under the Tax Equity and Fiscal Responsibility Act (TEFRA) compared to reimbursement for the same care under the prospective payment system rules; outcome measures such as the utilization of services, patient health, hospital charges, and Medicare expenditures for individuals admitted to demonstration sites to patients selected to serve as a control group; and estimation of the effects of implementing a national ventilator-dependent unit program, under TEFRA reimbursement, on utilization and Medicare expenditures.

Status: The contract has been extended from September 30, 1995 to February 29, 1996 without additional cost. This is the final extension. The case study report has been completed. Lewin/VHI has completed site visits to collect data and is concluding the data analysis.

93-050 Examination of Alternative Methods for Calculating Relative Values for Practice Expenses: University of Minnesota

Project No.:	500-92-0022DO02
Period:	June 1993–October 1995
Award:	Delivery Order in Master Contract
Funding:	$ 509,740
Principal Investigator:	Mark V. Pauly, Ph.D.
Awardee:	University of Minnesota
	(See page 209)
HCFA Project Officer:	Edgar A. Peden, Ph.D. Division of Payment Systems

Description: The purpose of this delivery order is to examine alternative methods for determining the practice expense components of the relative value scale for the Medicare fee schedule. To this end, it first examines two alternative measures of procedure costs-econometric cost functions and accounting methods. Based on these costs, volume and revenue outcomes are examined on a procedure and specialty basis under alternative methods of fee setting. The current method used to determine practice expense relative values were largely dictated in legislation which requires that they be determined for each procedure or service by specialty from the historic average charges and the practice expense portion of gross revenue. It also takes into account the volume shares for each specialty. Practice expenses do not include the value of the physician's own work related to performing services for patients or malpractice insurance expenses.

The Physician Payment Review Commission and some others, including the Harvard Resource-Based Relative Value Scale study team, have expressed a belief that the current method yields irrational results. Others have said that the results yield payments which are as inefficient or even less efficient than those which arose from the former Medicare customary, prevailing and reasonable physician payment system.

This project is the third in a series done by The Leonard Davis Institute of the University of Pennsylvania under a subcontract to Minnesota to develop practice cost pricing criteria. The two previous projects are completed and have been sent to the National Technical Information Service; the first discusses various theories of pricing ("Allocating Practice Costs: Conceptual Issues," accession number, PB92-172964). The second uses data to estimate the effects of different pricing schemes ("Allocating Practice Costs: Simulations and Other Empirical Work"). The unique feature of these three projects is that they include a scenario for the efficient allocation of physicians' practice expenses as well as the conceptually simpler methods which look only at covering costs. The work of this project uses and extends the methodologies developed in the earlier projects to determine practice relative value units on a procedure and specialty basis by developing at least two scenarios: one based on the economic efficiency criteria seen in Ramsey pricing; the other based on accounting practices.

Status: The Pennsylvania researchers have submitted a draft final report which is currently being reviewed. A final report is expected in early 1996.

95-070 Exploratory Study of the Effects of Managed Care on Urban Hospitals: ANASYS

Project No.:	500-95-0024
Period:	July 1995–March 1996
Funding:	$ 80,000
Award:	Contract
Principal Investigator:	Joshua S. Park
Awardee:	10805 Hickory Ridge Road, Suite 200B Columbia, MD 21044
HCFA Project Officer:	Jay Bae, Ph.D. Division of Payment Systems

Description: The growth of managed care organizations is rapidly changing the way hospitals conduct business in many parts of the country. Where the managed-care sector's presence is felt significantly, the hospitals must compete for contracts with these managed-care plans. Increasing shares of managed-care contracts, however, can affect the behavior of hospitals considerably. The purpose of this project is to develop alternative measures of managed care's impact by Metropolitan Statistical Areas, and explore the possibilities of using such measures in analyzing the impact of managed care on urban hospitals.

Status: This project was recently awarded and is in its early development stage.

90-018 Financing of Acquired Immunodeficiency Syndrome and Acquired Immunodeficiency Syndrome-Related Complex Treatment Costs by Medicaid and Medicare

Project No.:	18-C-99522/3
Period:	May 1990–March 1995
Funding:	$ 648,985
Award:	Cooperative Agreement
Principal Investigator:	Julia Hidalgo

Awardee:	Maryland Department of Health and Mental Hygiene Center for AIDS Services, Planning, and Development 201 West Preston Street Baltimore, MD 21201
HCFA Project Officer:	Penelope L. Pine Division of Health Information and Outcomes

Description: The State of Maryland has developed a longitudinal database focusing on human immunodeficiency virus (HIV)-infected people from 1981 through 1992. The project is expected to provide related illness information on the extent to which patient, provider, and payer characteristics influence cost and use of health services on expenditures in Maryland under the Medicaid and Medicare programs. Four major aspects to the study are to maintain the data systems of the Maryland Human Immunodeficiency Virus Information System as required to measure program use and financing; to compare and refine three different disease-staging approaches for predicting resource consumption and treatment outcomes during the course of the HIV disease; to retrospectively assess health services utilized by pediatric, adolescent, and adult patients with HIV; and to use annual utilization, reimbursement, and financing data to measure trends.

Status: The project is in its final year. Calendar year 1992 Medicaid data have been obtained and data analysis has begun. The three disease-staging approaches and classification models under study are the Severity Index for Adults with AIDS (SIAA), the Severity Classification for AIDS Hospitalizations (SCAH), and the Centers for Disease Control (CDC) Disease Classification System. SCAH has been applied to a longitudinal data set of adults with acquired immunodeficiency syndrome (AIDS) hospitalizations for 1983 and 1989 to predict long-term survival. Currently, SIAA and the CDC classification are being assessed and compared to SCAH to predict survival and health services utilization. Development of the Medicare data is underway. These papers have been presented at various professional meetings:

- Hildalgo, J.: "Medicaid, Does Enrollment Ensure Access to Care for Persons with AIDS?" AIDS Health Services Research Conference, December 1991.
- Hildalgo, J.: "Trends in the Public Financing of AIDS 1985–1990." AIDS Health Services Research Conference, December 1991.
- Hildalgo, J., Boreta, J.C., Beardsley, R., Chaisson, R., and Moore, R.: "Epidemiological Monitoring of AIDS Patients: The Maryland Experience." George Washington University meeting on Drug Development in the 1990's: The Legacy of AIDS.

Publications available include the following:

- Hildalgo, J.: "Development and Application of Statewide Acquired Immunodeficiency Syndrome Information Systems in Health Services Planning and Evaluation." *Evaluation and Program Planning*, 13:39–46, 1990.
- Hildalgo, J.: "Development of a Model Longitudinal Database to Measure Outcomes and Quality of Care Among Persons with AIDS." *Quality Review Bulletin*, pp. 355–363, October 1990.
- Moore, R.D., Hildalgo, J., Sugland, B.W., and Chaisson, R.: "Zidovudine and the Natural History of Acquired Immunodeficiency Syndrome." *The New England Journal of Medicine*, 324(20):1412–1416, May 16, 1991.

92-035 Geographic Practice Cost Index Assessment and Update

Project No.:	500-89-0050
Period:	April 1992–March 1995
Funding:	$ 643,794
Award:	Contract
Principal Investigator:	Gregory C. Pope, Ph.D.
Awardee:	Health Economics Research, Inc. 300 Fifth Avenue, 6th Floor Waltham, MA 02154
HCFA Project Officer:	Sherry A. Terrell, Ph.D. Division of Payment Systems
Mandate:	Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: A major change in Medicare physician payment rules encompassing three major elements—replacement of the reasonable charge payment mechanism with a fee schedule for physician services, replacement of the maximum allowable charge limit with new limiting charges, and establishment of national volume performance standards—was implemented on January 1, 1992. The fee schedule, composed of national uniform relative values for physician services, must be adjusted for the cost of medical practice in each Medicare payment locality. This geographic adjustment factor is termed the Medicare geographic practice cost index (GPCI). The purpose of this project was to assess the GPCI, published in Appendix C of the November 25, 1991, *Federal Register* 56(227), as amended in Appendix D of the December 2, 1993, *Federal Register* 58(230), and to update the work, practice expense, and malpractice expense component indexes with 1990 Census and other more recent data. The assessment process addressed methodology, proxy data, and new data sources. Weights for the various work, practice expense, and malpractice expense components of the index were updated with the latest available data. Methodologies were developed that might be used in future updates of the GPCI.

Status: This project has been completed. The 1990 income data from the Census Bureau and the most recent (1994) Fair Market Rental (FMR) data from the Department of Housing and Urban Development were obtained and analyzed. New sources for commercial rental data, including the Internal Revenue Service, the General Services Administration, and the U.S. Postal Service, were explored as possible substitutions for the FMR proxy data. Malpractice premium data for 1990, 1991, and 1992 were collected from an expanded number of underwriters, including physician-owned companies. Physician practice expense weights were updated with more recent (1989) American Medical Association socioeconomic data. Medical equipment and supplies cost data, transportation cost data, State sales (gross receipts) tax data, commercial rent data, and proxy data were reassessed. The three component indexes for work, practice expense, and malpractice were revised and published in the June 24, 1994, *Federal Register* 59(121) Notice of Proposed Rule Making. Subsequently, transitional GPCI values effective January 1995 and final GPCI values effective January 1996 were published in the December 8, 1994, *Federal Register* 59(235). The following detailed methodological reports and data are available from the National Technical Information Service:

- Updating the "Geographic Practice Cost Index: Revised Cost Shares," accession number PB94-161072.
- Updating the "Geographic Practice Cost Index: The Physician Work GPCI," accession number PB94-161080.
- Updating the "Geographic Practice Cost Index: The Practice Expense GPCI," accession number PB94-161098.
- Updating the "Geographic Practice Cost Index: The Malpractice GPCI," accession number PB94-161106.
- Comparison of the "GPCI Rental Index to Three Sources of Commercial Office Rents," accession number PB95-123311.
- Updating the "Geographic Practice Cost Index: Final Report," accession number PB95-231825.
- "1989-1992 County-Level Population-Weighted Malpractice Indices by Specialty" (Diskette), accession number PB95-503454.

The project findings also were used to support the related Report to Congress required by section 122(c) of the Social Security Act Amendments of 1994 (Public Law 103-432).

91-076 Hospital Market Dynamics and the Adoption of Expensive Medical Technology

Project No.:	17-C-90010/4
Period:	September 1991–September 1994
Funding:	$ 199,247
Award:	Cooperative Agreement
Principal Investigator:	Thomas J. Hoerger, Ph.D.
Awardee:	Health Policy Center Vanderbilt University Box 1503–Station B Nashville, TN 37235
HCFA Project Officer:	Alvin L. Freedman Dissemination Staff

Description: The project will study the interaction between hospital competition and the adoption of expensive medical technologies. The objectives are: to provide a better understanding of the interrelationships among hospital competition, reimbursement policy, and the adoption of expensive technologies; to analyze the effects of technology on hospital market structure; and to study how new technologies diffuse across diagnoses and from inpatient to outpatient services. The study will focus on technology adoption by hospitals in California, Florida, and Tennessee.

Status: A draft final report was submitted in December 1994. The main findings are: (1) Prospective Payment System (PPS) for Medicare and Medicaid for operating costs had the theoretical effect of lowering the cost of capital to labor; (2) empirically, the cost of capital declined as Medicare's move to PPS increased; (3) not-for-profit hospitals have lower costs of capital than for-profit hospitals; (4) PPS for capital under Medicare will have ambiguous effects on the cost of capital; (5) competition appears to reduce hospital investment; (6) hospital size is a dominant factor in technology adoption; and (7) government hospitals are less likely to adopt a technology than private not-for-profit hospitals.

94-112 Implementation and Evaluation of Ambulatory Patient Groups as an Outpatient Measurement and Financing Methodology in Maine

Project No.:	18-C-90410/1
Period:	September 1994–September 1996
Funding:	$ 263,300
Award:	Cooperative Agreement
Principal Investigator:	Amanda Attridge
Awardee:	State of Maine State House Station 102 9 Green Street Augusta, ME 04333
HCFA Project Officer:	Joseph M. Cramer Division of Payment Systems

Description: The project will establish a comprehensive all-payer outpatient database and will implement ambulatory patient groups (APG) as an outpatient measurement and financing methodology in Maine. The project will develop a comprehensive database for all hospital outpatient services

that can be used in health care policy, planning, research, and regulation. The project intends to provide the results of Maine's experience in the implementation of APGs and an evaluation of their potential to control health care costs.

Status: The base year data has been grouped into APGs for all hospitals. The APG groupings from each hospital and statewide were evaluated in light of grouping experience in other States and were found to be consistent. Weights have been assigned to the APGs and simulation models are being developed.

94-090 Improving Measurement of Hospital Output

Project No.:	17-C-90447/9
Period:	September 1994–May 1996
Funding:	$ 285,924
Award:	Cooperative Agreement
Principal Investigator:	Grace M. Carter, Ph.D.
Awardee:	The RAND Corporation 1700 Main Street P.O. Box 2138 Santa Monica, CA 90407-2138
HCFA Project Officer:	Philip G. Cotterill, Ph.D. Division of Payment Systems

Description: The purpose of this project is to explore the policy implications of an improved way of measuring hospital output by combining the diagnosis-related group system for classifying discharges with the California standard measurement unit system for measuring the intensity of care per case-mix constant discharge. The project will estimate the annual change in California hospital output and compare this estimate with the method currently used by the Health Care Financing Administration. In addition, the project will analyze the extent to which case-mix constant intensity determines differences in cost among hospital groups. Since measures of hospital output are critical for the prospective payment system, the results of this project will help to validate current policies including the annual update and other adjustment factors.

Status: The project has been extended until May 1996 to permit completion of analyses of DRG weights and pricing strategies. Data processing for this task has taken longer than anticipated. A final report is expected by late Summer 1996.

94-102 Levels and Determinants of Hospital Inefficiency

Project No.:	17-C-90285/4-01
Period:	September 1994–March 1996
Award:	Cooperative Agreement
Funding:	$ 146,042
Principal Investigators:	Thomas N. Chirikos, Ph.D. and Alan M. Sear, Ph.D.
Awardee:	University of South Florida 4202 Fowler Avenue Tampa, Florida 33620
HCFA Project Officer:	Edgar A. Peden, Ph.D. Division of Payment Systems

Description: The principal objective of this project is to quantify current levels and historical rates of change in hospital inefficiency. To accomplish this goal the investigators are using statistical analyses, including Data Envelopment Analysis and Frontier Cost Analysis. The database used includes longitudinal information for hospitals in the state of Florida. As part of this analysis, the project will identify the determinants of the level and changes in inefficiency, both within hospitals (e.g., organizational characteristics, arrangements with the medical staff, practice patterns) and those in the external environment to hospitals (e.g., the degree of competition in the local health care market, regulations, technological diffusion). Finally, it will prepare a set of policy recommendations based on the empirical findings that emphasize how hospital management practices and/or external market characteristics might be shaped by Federal policy makers in order to further reduce hospital inflation.

Status: The investigators are currently conducting their analyses and expect to submit a final report in March 1996.

94-110 Maine Medicare Volume Performance Standard Demonstration Project

Project No.:	19-C-90401/1
Period:	September 1994–November 1997
Funding:	$ 341,750
Award:	Cooperative Agreement
Principal Investigator:	Robert B. Keller, M.D.
Awardee:	Maine Medical Assessment Foundation P.O. Box 4682 Augusta, ME 04330-1682
HCFA Project Officer:	Mark A. Krause, Ph.D. Division of Payment Systems

Description: This research will assess the feasibility and value of a State-level Medicare volume performance standard (MVPS). Among other individuals, analysts at the Physician Payment Review Commission have raised questions regarding the effectiveness of the current national volume performance standard methodology. These analysts have argued that the current MVPS program may not be accomplishing its intended goal of providing an incentive for physicians to avoid excessive increases in the volume of services they furnish to Medicare beneficiaries. The Maine Medical Assessment Foundation (MMAF) in conjunction

with the Urban Institute will analyze national and State-level physician data to provide information about the volume (rate) and intensity (relative value units) of medical services provided to Medicare beneficiaries in the State of Maine. MMAF will utilize these data to create analytic files and reports on population-based utilization rates of services and the intensity of those services. Data will be provided to 10 specialty study groups. This information will be used by physicians to change their practice behaviors by improving the efficiency and appropriateness of the care they provide. Access and quality of care will be monitored closely by an advisory committee, and all aspects and implications of the project will be evaluated by the project staff and an external reviewer.

Status: The project continues in the early development stage.

93-084 **Medicare-Designated Cataract Surgery Providers: Cataract Eye Center of Cleveland, Inc.** (Formerly, Medicare Designated Cataract Surgery Providers)

Project No.:	95-P-30005/5
Period:	January 1993–April 1996
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Samuel M. Salamon, M.D.
Awardee:	Cataract Eye Center of Cleveland, Inc. 2322 East 22nd Street, Suite 307 Cleveland, OH 44115
HCFA Project Officer:	Cynthia K. Mason Division of Delivery Systems and Financing

Description: This physician group practice in Ohio is one of four sites of the demonstration begun by the Office of Research and Demonstrations to assess the feasibility of a negotiated all-inclusive price concept for cataract surgery. The negotiated price covering physician, facility, and intraocular lens costs for the procedure are being tested in three metropolitan statistical areas: Cleveland, Ohio; Dallas/ Fort Worth, Texas; and Phoenix, Arizona. Participation by providers and beneficiaries at each site is completely voluntary.

Status: In April 1993, this site successfully implemented the 3-year demonstration.

93-082 **Medicare-Designated Cataract Surgery Providers: Medical Eye Associates, Inc.** (Formerly, Medicare Designated Cataract Surgery Providers)

Project No.:	95-P-30002/5
Period:	January 1993–April 1996
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Boris Komrovsky, M.D.
Awardee:	Medical Eye Associates, Inc. 7003 Pearl Road Middleburg Heights, OH 44130
HCFA Project Officer:	Cynthia K. Mason Division of Delivery Systems and Financing

Description: This physician group practice in Ohio is one of four sites of the demonstration begun by the Office of Research and Demonstrations to assess the feasibility of a negotiated all-inclusive price concept for cataract surgery. The negotiated price covering physician, facility, and intraocular lens costs for the procedure are being tested in three metropolitan statistical areas: Cleveland, Ohio; Dallas/ Fort Worth, Texas; and Phoenix, Arizona. Participation by providers and beneficiaries at each site is completely voluntary.

Status: In April 1993, this site successfully implemented the 3-year demonstration. However, effective December 31, 1994, the site withdrew from the demonstration, citing administrative considerations.

93-081 **Medicare-Designated Cataract Surgery Providers: National Medical Enterprises** (Formerly, Medicare Designated Cataract Surgery Providers)

Project No.:	95-P-30001/6
Period:	January 1993–April 1996
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Reynold J. Jennings
Awardee:	National Medical Enterprises Doctors Hospital of Dallas 9440 Poppy Drive Dallas, TX 75218
HCFA Project Officer:	Cynthia K. Mason Division of Delivery Systems and Financing

Description: This hospital in Texas is one of four sites of the demonstration begun by the Office of Research and Demonstrations to assess the feasibility of a negotiated all-inclusive price concept for cataract surgery. The negotiated

price covering physician, facility, and intraocular lens costs for the procedure are being tested in three metropolitan statistical areas: Cleveland, Ohio; Dallas/Fort Worth, Texas; and Phoenix, Arizona. Participation by providers and beneficiaries at each site is completely voluntary.

Status: In April 1993, this site successfully implemented the 3-year demonstration.

93-083 **Medicare-Designated Cataract Surgery Providers: Southwestern Eye Center, Ltd.** (Formerly, Medicare Designated Cataract Surgery Providers)

Project No.:	95-P-30003/9
Period:	January 1993–April 1996
Funding:	Waiver only
Award:	Grant
Principal Investigator:	L. Lothaire Bluth, M.D.
Awardee:	Southwestern Eye Center, Ltd. 1818 East Southern Avenue, Suite 18 Mesa, AZ 85204
HCFA Project Officer:	Cynthia K. Mason Division of Delivery Systems and Financing

Description: This ambulatory surgery center in Arizona is one of four sites of the demonstration begun by the Office of Research and Demonstrations to assess the feasibility of a negotiated all-inclusive price concept for cataract surgery. The negotiated price covering physician, facility, and intraocular lens costs for the procedure are being tested in three metropolitan statistical areas: Cleveland, Ohio; Dallas/Fort Worth, Texas; and Phoenix, Arizona. Participation by providers and beneficiaries at each site is completely voluntary.

Status: In April 1993, this site successfully implemented the 3-year demonstration.

89-006 **Medicare Participating Heart Bypass Center Demonstration Evaluation**

Project No.:	500-87-0029TO04
Period:	June 1989–December 1994
Funding:	$ 969,662
Award:	Technical Support: Evaluation of Demonstrations
Principal Investigator:	Robert J. Rubin, M.D.
Awardee:	Lewin/VHI, Inc. 9300 Lee Highway, Suite 400 Fairfax, VA 22031-1207
HCFA Project Officer:	Armen H. Thoumaian, Ph.D. Division of Delivery Systems and Financing

Description: The awardee assisted the Health Care Financing Administration (HCFA) in implementing and evaluating a 3-year demonstration designed to assess the feasibility of a negotiated all-inclusive pricing arrangement for coronary artery bypass graft surgery. Lewin/VHI assisted HCFA in preparing an evaluation and implementation plan, monitoring the demonstration sites, collecting and analyzing data, and preparing the final evaluation report. Some key questions addressed during the evaluation are these:

- Did the demonstration result in a net cost savings to the Medicare program?
- What was the source of any volume increases at the demonstration sites?
- What aspects of a demonstration site are attractive to Medicare beneficiaries and to referring physicians?
- Was the quality of care at the demonstration sites equivalent to that provided at the sites prior to the demonstration?

Status: HCFA negotiated with the finalists and selected four demonstration sites in January 1991. Implementation of the demonstration began in May 1991. Lewin/VHI completed the design of the evaluation and began data collection at the sites. In December 1992, HCFA expanded the demonstration to include three additional sites from among the remaining six recommended hospitals bringing the total number of demonstration sites to seven. These additional sites began service delivery under the demonstration in May and June 1993. In September 1993, the evaluation contract with Lewin/VHI was modified to include the three new sites. The final evaluation report from Lewin/VHI on the first 3 years of the demonstration was completed in December 1994.

The final reports are available from the National Technical Information Service:

- "Medicare Participating Heart Bypass Center Demonstration: Final Evaluation Report: Volume I- The First Three Years and Appendices to Volume I," accession number PB96-127626.
- "Medicare Participating Heart Bypass Center Demonstration: Final Evaluation Report: Volume II- Marketing Activities of Participating Hospitals and Executive Summary," accession number PB96-125570.
- "Medicare Participating Heart Bypass Center Demonstration: Appropriateness Study," accession number PB96-127782.
- "Medicare Participating Heart Bypass Center Demonstration: Evaluation Design and Data Collection Design," accession number PB96-127808.

94-010 Medicare Participating Heart Bypass Center Demonstration Extended Evaluation

Project No.:	500-92-0013DO03
Period:	July 1994–February 1997
Funding:	$ 363,318
Award:	Delivery Order in Master Contract
Principal Investigator:	Jerry Cromwell, Ph.D.
Awardee:	Health Economics Research, Inc. (See pages 203–204)
HCFA Project Officer:	Armen H. Thoumaian, Ph.D. Division of Delivery Systems and Financing

Description: The awardee's objective is to assist the Health Care Financing Administration (HCFA) in the continued evaluation of a 5-year extended demonstration designed to assess the feasibility of a negotiated all-inclusive pricing arrangement for coronary artery bypass graft surgery while maintaining high quality care. Health Economics Research, Inc. (HERI), will assist HCFA by continuing the demonstration evaluation plan established under a previous contract, by monitoring the demonstration sites, by collecting and analyzing data, and by preparing the final evaluation report. Some key questions to be addressed during the evaluation are these:

- Did the demonstration result in a net cost savings to the Medicare program?
- What was the source of any volume increases at the demonstration sites?
- What aspects of a demonstration site are attractive to Medicare beneficiaries and to referring physicians?
- Was the quality of care at the demonstration sites equivalent to that provided at the sites prior to the demonstration?

Status: HCFA negotiated with the finalists and selected four demonstration sites in January 1991. Implementation of the demonstration at three sites began in May 1991. In December 1992, HCFA expanded the demonstration to include three additional sites from among the remaining six recommended hospitals, bringing the total number of demonstration sites to seven. These additional sites began service delivery under the demonstration in May and June 1993. In Spring 1994, at their request, the first four sites were allowed to continue under the demonstration for an additional 2 years. In June 1994, a new evaluation contract was awarded to HERI to extend the evaluation of the seven sites for the remainder of their participation. The final evaluation report is expected in February 1997.

91-006 Medicare Participating Heart Bypass Center Demonstration: Georgia

Project No.:	95-P-99602/4
Period:	January 1991–June 1996
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Susan White
Awardee:	Saint Joseph's Hospital of Atlanta 5665 Peachtree Dunwoody Road, NE. Atlanta, GA 30342-1701
HCFA Project Officer:	Armen H. Thoumaian, Ph.D. Division of Delivery Systems and Financing

Description: This hospital in Georgia is one of seven sites of the demonstration begun by the Office of Research and Demonstrations to assess the feasibility of a negotiated all-inclusive pricing arrangement for coronary artery bypass graft (CABG) procedures while maintaining high quality care. Hospitals and physicians participating in the project receive a global payment covering hospital and related physician services for CABG surgery. Participation in the demonstration is completely voluntary for Medicare beneficiaries. Hospitals and physicians not participating in the demonstration will continue to provide services and receive payment under Medicare's conventional payment method.

Status: This hospital, successfully ending its 3-year participation in spring 1994, requested and received a 2-year continuation under the demonstration until June 30, 1996.

93-011 Medicare Participating Heart Bypass Center Demonstration: Indiana

Project No.:	95-P-99599/5
Period:	January 1993–June 1996
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Stephen J. Jay, M.D.
Awardee:	Methodist Hospital of Indiana, Inc. 1701 North Senate Boulevard Indianapolis, IN 46206-1367
HCFA Project Officer:	Armen H. Thoumaian, Ph.D. Division of Delivery Systems and Financing

Description: This hospital in Indiana is one of seven sites of the demonstration begun by the Office of Research and Demonstrations to assess the feasibility of a negotiated all-inclusive pricing arrangement for coronary artery bypass graft (CABG) procedures while maintaining high quality care. Hospitals and physicians participating in the project

receive a global payment covering hospital and related physician services for CABG surgery. Participation in the demonstration is completely voluntary for Medicare beneficiaries. Hospitals and physicians not participating in the demonstration will continue to provide services and receive payment under Medicare's conventional payment method.

Status: This hospital successfully implemented the 3-year demonstration in Spring 1993.

91-003 Medicare Participating Heart Bypass Center Demonstration: Massachusetts

Project No.:	95-P-99592/1
Period:	January 1991–June 1996
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Paul Drew
Awardee:	University Hospital Boston University Medical Center 88 East Newton Street Boston, MA 02118-2393
HCFA Project Officer:	Armen H. Thoumaian, Ph.D. Division of Delivery Systems and Financing

Description: This hospital in Massachusetts is one of seven sites of the demonstration begun by the Office of Research and Demonstrations to assess the feasibility of a negotiated all-inclusive pricing arrangement for coronary artery bypass graft (CABG) procedures while maintaining high quality care. Hospitals and physicians participating in the project receive a global payment covering hospital and related physician services for CABG surgery. Participation in the demonstration is completely voluntary for Medicare beneficiaries. Hospitals and physicians not participating in the demonstration will continue to provide services and receive payment under Medicare's conventional payment method.

Status: This hospital, successfully ending its 3-year participation in Spring 1994, requested and received a 2-year continuation under the demonstration until June 30, 1996.

91-004 Medicare Participating Heart Bypass Center Demonstration: Michigan

Project No.:	95-P-99591/5
Period:	January 1991–June 1996
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Richard Prager, M.D.
Awardee:	St. Joseph Mercy Hospital Catherine McAuley Health System 5301 East Huron River Drive Ann Arbor, MI 48106
HCFA Project Officer:	Armen H. Thoumaian, Ph.D. Division of Delivery Systems and Financing

Description: This hospital in Michigan is one of seven sites of the demonstration begun by the Office of Research and Demonstrations to assess the feasibility of a negotiated all-inclusive pricing arrangement for coronary artery bypass graft (CABG) procedures while maintaining high quality care. Hospitals and physicians participating in the project receive a global payment covering hospital and related physician services for CABG surgery. Participation in the demonstration is completely voluntary for Medicare beneficiaries. Hospitals and physicians not participating in the demonstration will continue to provide services and receive payment under Medicare's conventional payment method.

Status: This hospital, successfully ending its 3-year participation in Spring 1994, requested and received a 2-year continuation under the demonstration until June 30, 1996.

91-005 Medicare Participating Heart Bypass Center Demonstration: Ohio

Project No.:	95-P-99597/5
Period:	January 1991–June 1996
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Kamilla K. Sigafoos
Awardee:	Ohio State University Hospitals 450 West 10th Avenue Columbus, OH 43210-1228
HCFA Project Officer:	Armen H. Thoumaian, Ph.D. Division of Delivery Systems and Financing

Description: This hospital in Ohio is one of seven sites of the demonstration begun by the Office of Research and Demonstrations to assess the feasibility of a negotiated all-inclusive pricing arrangement for coronary artery bypass graft (CABG) procedures while maintaining high quality care. Hospitals and physicians participating in the project receive a global payment covering hospital and related physician services for CABG surgery. Participation in the demonstration is completely voluntary for Medicare beneficiaries. Hospitals and physicians not participating in the demonstration will continue to provide services and receive payment under Medicare's conventional payment method.

Status: This hospital, successfully ending its 3-year participation in Spring 1994, requested and received a 2-year continuation under the demonstration until June 30, 1996.

93-010 Medicare Participating Heart Bypass Center Demonstration: Oregon

Project No.:	95-P-99604/0
Period:	January 1993–June 1996
Funding:	Waiver only
Award:	Grant
Principal Investigator:	John V. Fletcher
Awardee:	St. Vincent Hospital and Medical Center 9155 SW. Barnes Road Portland, OR 97225
HCFA Project Officer:	Armen H. Thoumaian, Ph.D. Division of Delivery Systems and Financing

Description: This hospital in Oregon is one of seven sites of the demonstration begun by the Office of Research and Demonstrations to assess the feasibility of a negotiated all-inclusive pricing arrangement for coronary artery bypass graft (CABG) procedures while maintaining high quality care. Hospitals and physicians participating in the project receive a global payment covering hospital and related physician services for CABG surgery. Participation in the demonstration is completely voluntary for Medicare beneficiaries. Hospitals and physicians not participating in the demonstration will continue to provide services and receive payment under Medicare's conventional payment method.

Status: This hospital successfully implemented the 3-year demonstration in Spring 1993.

93-012 Medicare Participating Heart Bypass Center Demonstration: Texas

Project No.:	95-P-99603/6
Period:	January 1993–June 1996
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Michael D. Israel
Awardee:	St. Luke's Episcopal Hospital Texas Medical Center 6720 Bertner Street Houston, TX 77030
HCFA Project Officer:	Armen H. Thoumaian, Ph.D. Division of Delivery Systems and Financing

Description: This hospital in Texas is one of seven sites of the demonstration begun by the Office of Research and Demonstrations to assess the feasibility of a negotiated all-inclusive pricing arrangement for coronary artery bypass graft (CABG) procedures while maintaining high quality care. Hospitals and physicians participating in the project receive a global payment covering hospital and related physician services for CABG surgery. Participation in the demonstration is completely voluntary for Medicare beneficiaries. Hospitals and physicians not participating in the demonstration will continue to provide services and receive payment under Medicare's conventional payment method.

Status: This hospital successfully implemented the 3-year demonstration in Spring 1993.

94-011 Medicare Preferred Provider Organization (Medicare Choices Demonstration)

Project No.:	500-92-0011DO05
Period:	July 1994–February 1996
Funding:	$ 560,040
Award:	Delivery Order in Master Contract
Principal Investigator:	Merrile Sing, Ph.D.
Awardee:	Mathematica Policy Research, Inc. (See page 204)
HCFA Project Officer:	Victor G. McVicker Division of Delivery Systems and Financing

Description: Mathematica Policy Research, Inc. (MPR) is to assist the Health Care Financing Administration (HCFA) in the design and implementation of the Medicare Choices Demonstration. MPR will work with HCFA to develop guidelines for plan participation in the demonstration, recruit potential demonstration sites, and assist HCFA with demonstration implementation activities. The purpose of this demonstration is to test the receptivity of Medicare beneficiaries to a broad range of managed care delivery system options and to evaluate the suitability of such options for the Medicare program. This demonstration will also provide a head start on developing solutions to a wide range of implementation issues (such as risk sharing, payment methods, certification requirements, and quality monitoring systems) which would be associated with some legislative expansions of Medicare managed care currently under consideration. The solicitation for proposals will be conducted in two stages. In the first stage, information about the demonstration will be provided to managed care plans and provider groups through direct mail and by contracting large employer and health trade organizations such as the Group Health Association of America and the Managed Care Review Association.

Interested organizations will be asked to complete a preapplication form. HCFA will target nine market areas to contact and recruit individual organizations for the demonstration, but will also consider innovative proposals from other parts of the country. The returned preapplication forms will be screened, and selected organizations will be invited to complete and submit a second, more complete application within a 2-month period. The demonstration sites will be selected based on a review of these applications with an award expected in early 1996. The demonstration will run 3 to 5 years.

Status: In June 1995, HCFA solicited for participating plans through a wide-scale direct mailing to managed care organizations, associations and providers. HCFA targeted sites in the following areas: Hartford, Connecticut; Philadelphia, Pennsylvania; Atlanta, Georgia; Jacksonville, Florida; New Orleans, Louisiana; Columbus, Ohio; Louisville, Kentucky; Houston, Texas; and Sacramento, California. HCFA also encouraged applicants from rural areas. The preapplications were reviewed by 10 HCFA technical evaluation teams, composed of staff from various HCFA central office components and regional offices. As a result of the pre-application process, 52 organizations have been asked to submit full applications. Organizations must submit full applications to HCFA by December 15, 1995.

92-003 Medicare Volume Performance Standards for Voluntary Physician Organizations

Project No.:	17-C-90129/1
Period:	October 1991–August, 1995
Funding:	$ 846,356
Award:	Cooperative Agreement
Principal Investigator:	Christopher P. Tompkins, Ph.D.
Awardee:	Brandeis University Heller Graduate School Institute for Health Policy 415 South Street P.O. Box 9110 Waltham, MA 02254-9110
HCFA Project Officer:	Teresa L. DeCaro Division of Payment Systems
Mandate:	Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239)

Description: This project is an extension of a prior study (99-C-98526/1) that explored the cross-sectional and longitudinal volume and intensity of Medicare service utilization by physician group practice characteristics. The final report for that study, "Setting Medicare Volume Performance Standards for Large Primary Care Medical Practices," accession number PB93-190353, is available from the National Technical Information Service. Per beneficiary utilization patterns were measured under three different service definitions including: physician services provided by the group practice only, all physician services covered under the Medicare volume performance standards (MVPS), and all Medicare-covered services. The most stable service definition—average total MVPS service reimbursements provided to a unique patient seen (RPUPS) by the practice—had a mean absolute percent error (MAPE) of 10.9 percent. The current study seeks to design payment policy options that would provide incentives for qualified physician organizations in the fee-for-service sector to seek administrative and clinical decision making efficiencies beyond the national MVPS service definition, to include the full spectrum of Medicare services.

Status: This project involved calculating RPUPs and MAPEs for the same (or similar) service definitions used in the prior study, but in a significantly improved data environment with better case-mix adjustment to assure sufficient data stability to support the policy options under consideration. In particular, employee identification numbers (EINs) were used to define a provider practice, measures were constructed with 100 percent national claims history data, and nationally uniform payment policies under the Medicare Fee Schedule limited measured variance due to geographic differences in billing and payment. Case studies involving 10 multispecialty group practices were used to assist in developing criteria for participation; to understand policy, market, and administrative conditions that would encourage participation; and to develop a model for investigating an organization's likely strategic response to these new incentives. The final report entitled, "Models for Medicare Payment System Reform Based on Group-Specific Volume Performance Standards," accession number PB95-261129, is available from the National Technical Information Service. The report presents the policy context for GVPS. It focuses largely on the most robust model—a payment target for each participating physician organization which reflects average total Part A and Part B reimbursements per beneficiaries seen. This model, relative to more limited service definitions, provides the greatest opportunity to economize and the strongest incentives to manage the full spectrum of patient care. Optional policy parameters for the combined Part A and Part B model are offered for setting and updating the target, measuring actual performance, establishing the risk-sharing structure, and setting participation criteria that would include a rigorous quality assurance and case management component. Finally, simulations are presented demonstrating the potential for significant savings under the Medicare fee-for-service program along with lump sum rewards larger than foregone revenues to participating groups who beat their targets. Sensitivity analyses demonstrate Medicare savings will fluctuate as, will size of annual rewards to participants relative to foregone revenue. Varying assumptions include market share (number of beneficiaries seen), patient capture ratio (portion of average RPUPS provided by the participating practice), and efficiency in clinical decisionmaking (change in RPUPS over time).

94-130 Monitoring and Evaluation of the Medicare Cataract Surgery Alternate Payment Demonstration

Project No.:	500-94-0038
Period:	August 1994–August 1996
Funding:	$ 496,049
Award:	Contract
Principal Investigator:	Monica Noether, Ph.D.
Awardee:	Abt Associates, Inc. 55 Wheeler Street Cambridge, MA 02138
HCFA Project Officer:	Cynthia K. Mason Division Delivery Systems and Financing

Description: The objective of this contract is to assist the Health Care Financing Administration in the monitoring and evaluation of a demonstration to assess the feasibility of an all-inclusive negotiated price concept for cataract surgery. The evaluation will be conducted under a revised plan using the Johns Hopkins University Cataract Patient Outcome Research Team database in place of control site data. The negotiated price covering physician, facility, and intraocular lens costs for the procedure have been tested at four and continues to be tested at three sites in three metropolitan statistical areas. Participation by providers and beneficiaries at each site is completely voluntary. Some key questions to be addressed during the evaluation are these:

- Did the demonstration result in a net cost savings to the Medicare program?
- What is the change over time in the use of services included and the use of services excluded from the bundle?
- How satisfied are beneficiaries with cataract surgery provided under a demonstration-bundled rate compared to patients undergoing cataract surgery paid for according to traditional Medicare principles?
- Did the quality of care at the demonstration sites change from the care provided at the same sites prior to the demonstration?

Status: An interim report based on the first year's data is expected to be completed in late Fall 1995. The final report is expected in late Spring 1996.

95-055 Per Case Payment to Encourage Risk Management and Service Integration in the Inpatient Acute Care Setting

Project No.:	500-92-0013DO05
Period:	September 1995–September 1997
Funding:	$ 511,408
Award:	Delivery Order in Master Contract
Principal Investigator:	Janet B. Mitchell, Ph.D.
Awardee:	Health Economics Research, Inc. (See page 203)
HCFA Project Officer:	Teresa L. DeCaro Division of Payment Systems

Description: The purpose of this project is to design a demonstration, conduct a solicitation, and provide technical assistance during the implementation of a per case payment system. Discounted lump sum payments based on each participating physician hospital organization's historical payment experience for all diagnosis-related groups (DRGs) will be made to the representative organization. The demonstration seeks to measure actual provider behavioral response, patient satisfaction, health outcomes, and overall impact on the Medicare program given a financial risk-sharing intervention for acute Medicare Part A and Part B inpatient services. This demonstration is intended to provide important understanding about the administrative complexities, their associated costs, and other implementation issues surrounding a medical staff payment approach. This demonstration builds on research conducted under two prior studies (500-92-0020DO07 and 18-C-90038/3) investigating alternative payment options for medical staffs that would promote efficiency and improve service delivery during acute inpatient stays.

Status: This project is in an early development phase.

94-093 Physician Capitation for Medicare Services: Feasibility Study and Demonstration Design

Project No.:	500-92-0011DO04
Period:	January 1994–November 1995
Funding:	$ 305,596
Award:	Delivery Order in Master Contract
Principal Investigator:	Lyle Nelson, Ph.D.
Awardee:	Mathematica Policy Research, Inc. (See page 204)
HCFA Project Officer:	Brigid Goody, Sc.D. Division of Delivery Systems and Financing

Description: The purpose of this project is to build on an earlier Health Care Financing Administration (HCFA) funded project in which Mathematica Policy Research, Inc. (MPR), and the Medical Group Management Association (MGMA) designed a demonstration of direct capitation of medical groups. In this project, the contractor considers a broader range of risk-based payment arrangements and expands the set of potential demonstrations to include independent practice associations and integrated delivery systems in addition to medical groups. The project also includes an analysis of HCFA data to explore the feasibility of bundling for selected medical conditions.

Status: A draft report entitled "Should Medicare Place Physician Groups at Financial Risk: An Assessment of Alternative Demonstration Strategies" is currently under review. This report presents an examination of the extent to which physician groups currently accept risk from health maintenance organizations (HMOs) and other managed care organizations, an evaluation of a variety of risk-based payment options and a synopsis of discussions with provider representatives. The investigators report that there are mixed feelings among physician groups regarding potential interest in a demonstration of risk-based payment under Medicare. Although many physician groups have entered into risk-based arrangements with HMOs, attempts to develop similar arrangements between physician groups and the Medicare program would present some unique challenges. In particular, physician groups would be responsible for many functions currently performed by HMOs including the development of insurance products attractive to beneficiaries and administrative functions including paying provider claims.

A draft report on the feasibility of bundling for selected medical conditions is expected in November 1995.

89-003 **Physician Preferred Provider Organization Demonstration Sites: Minnesota** (Formerly, Physician Preferred Provider Organization Demonstration Sites)

Project No.:	95-C-99346/5
Period:	January 1989–December 1994
Funding:	$ 546,957
Award:	Cooperative Agreement
Principal Investigator:	M. Nazie Eftekhari
Awardee:	The Araz Group 8500 Normandale Lake Boulevard, Suite 2050 Bloomington, MN 55437
HCFA Project Officer:	Victor G. McVicker Division of Delivery Systems and Financing

Description: The Araz Group (formerly, Family Health Plan) is one of five preferred provider organization (PPO) sites selected for participation in the Medicare physician PPO pilot demonstration. The Araz Group contracts directly with employers in the Minneapolis-St. Paul area to enroll their employee groups into the PPO. The Araz Group offers a network of cost-effective providers and a claims-based utilization review program to control the volume of service use. The Araz Group's utilization review program includes preadmission certification, retrospective review, outpatient management, and case management. For the Medicare demonstration, the Araz Group is focusing on enrolling Medicare beneficiaries through employer retiree benefit plans. On January 1, 1992, the Araz Group began servicing Medicare beneficiaries under contracts with employer retiree groups.

Status: At the close of the third and final year of operation, the Araz Group continues to serve the same two employers, Minnegasco and Northwest Airlines. Minnegasco, a local gas utility with an average of about 830 retirees, is self-insured, and the retirees share in the cost of the plan. Northwest Airlines has an average of about 200 retirees under the demonstration and is self-insured. On average there were 458 participating providers in the Medicare provider network, 27 percent was primary care and 73 percent was specialty care. The demonstration ended on December 31, 1994.

93-051 **Prospective Per Case Payment for Episodes of Hospital Care** (Formerly, Per Case Prospective Payment for Episodes of Hospital Care)

Project No.:	500-92-0020DO07
Period:	June 1993–October 1995
Funding:	$ 644,052
Award:	Delivery Order in Master Contract
Principal Investigator:	Janet B. Mitchell, Ph.D.
Awardee:	Health Economics Research, Inc. (See page 206)
HCFA Project Officer:	Teresa L. DeCaro Division of Payment Systems

Description: This study seeks to produce alternative prospective per case payment models for episodes of hospitalization that expand the current boundaries of payment consolidation under Medicare's fee-for-service reimbursement policies. Specific tasks include: defining episodes of care that are anchored to acute hospitalizations; analyzing service bundles that make up the episodes; identifying and analyzing design, administrative, legal, transition, and other issues important to the potential implementation of selected models; calculating payment weights; and conducting "spending neutral" impact simulations of selected payment models. A technical advisory panel (TAP) made up of experts in research, medicine, group practice and hospital administration, claims data collection and management, and contract negotiations are providing guidance and feedback to the awardee throughout the life of the project.

Status: Using the Health Care Financing Administration's 1992 5-month, 100 percent hospital admission and episode database, descriptive analyses of physician service bundles are presented in an interim report. Bundles include all

physician services associated with an acute hospitalization from the day of admission to the day of discharge. Expanded bundles including windows up to 30 days prior to admission and 90 days post-discharge are also examined. These data are analyzed for appropriateness of window definitions and systematic differences in severity of illness within diagnosis-related groups (DRGs) by hospital characteristics. The recent final report entitled "Per Case Prospective Payment for Episodes of Hospital Care" has been received and is currently under review. This report presents payment models that include all DRGs for services provided during the inpatient stay. One model bundles physician services only. Another combines facility prospective payment (PPS) with bundled physician services. Payments would be made in a lump sum to an entity representing physicians in the first case, and both physicians and hospitals in the second. The models adjust for outliers, transfers, teaching and disproportionate share, and geographic cost differences. Case studies are presented examining provider, administrative and legal issues. Impact simulations are reported by hospital type and geographic region. Case payment could result in considerable redistribution across medical staffs. Medical staffs in teaching hospitals and in large urban hospitals would lose money on average, while those in nonteaching and in rural hospitals would make money. Staffs in the Mid-Atlantic region would experience large losses, while those in the West (particularly in sparsely populated states) would gain. Policy implications are explored including model refinements and transition options that could minimize the redistributional consequences of implementing a per case payment policy nationally.

95-002 Second Revision of the Medicare Geographic Practice Cost Index (GPCI)

Project No.:	500-92-0002
Period:	July 1995–June 1996
Funding:	$ 155,012
Award:	Contract
Principal Investigator:	Gregory C. Pope, Ph.D.
Awardee:	Health Economics Research, Inc. (See page 206)
HCFA Project Officer:	Benson L. Dutton Division of Payment Systems
Mandate:	Omnibus Reconciliation Act of 1990 (Public Law 101-508)

Description: By law, the Health Care Financing Administration (HCFA) is mandated to review and if necessary update the Geographic Practice Cost Index (GPCI) every 3 years. HCFA is required to use the best and most current data available to complete this task. Health Economics Research, Inc. (HERI) has been awarded a contract to take on the responsibility of reviewing and revising the GPCI. HERI will review current GPCI components that include but are not limited to: cost shares; wage indices; office rental index; malpractice premium index; Relative Value Units and population weights; and geographic definition/crosswalks. These elements will be used to compute work, practice expense, and malpractice GPCIs. The impact of changes in the components and the redistributional effects resulting from the revision will also be considered. HERI will produce periodic reports on the project's status as well as the requisite documentation for the accompanying data files.

Status: To date, HERI has delivered an Analysis Plan providing project detail describing their proposed analytical methods. In addition, HERI is in the process of collecting and reviewing data for the project.

91-016 Staff-Assisted Home Dialysis Demonstration

Project No.:	500-87-0030TO09
Period:	June 1991–December 1995
Funding:	$ 914,203
Award:	Technical Support: Evaluation of Demonstrations
Principal Investigator:	Andrea Hassol
Awardee:	Abt Associates, Inc. 55 Wheeler Street Cambridge, MA 02138-1168
HCFA Project Officer:	Bonnie M. Edington Division of Health Information and Outcomes
Mandate:	Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: This demonstration was to test whether providing Medicare-paid home hemodialysis assistants for end stage renal disease (ESRD) patients meeting stringent eligibility criteria (e.g., bed- or wheelchair-bound) is cost effective, in that it reduces Medicare-covered ambulance costs for transporting patients to maintenance dialysis in facilities or reduces hospital admissions attributed to transportation-related problems. The legislation limits the experimental benefit to a maximum of 800 patients and stipulates a detailed rate setting formula.

Status: Extensive outreach efforts were undertaken, however, only 91 patients were enrolled in the demonstration. The eligibility criteria tended to characterize patients too ill for home hemodialysis. Although 46 patients had been randomly assigned to the experimental group, 10 were withdrawn from the demonstration and 12 died before they could receive the experimental service. The overall mortality rate among all enrollees was 78 percent over a period of 2 years and 9 months, in contrast to a 44 percent rate among the general ESRD population. Since the

demonstration did not have a sufficient number of patients for meaningful statistical analysis, a series of related research studies has been undertaken: comparing and contrasting demonstration enrollees with ambulance-using ESRD patients not enrolled in the demonstration; identifying detailed characteristics of ESRD ambulance users; assessing reasons for and alternatives to ambulance transport to dialysis; comparing and contrasting ESRD nursing home residents with other ESRD patients; and analyzing the components of cost for high-cost ESRD patients. An interim report was submitted to Congress in January 1993. The final Report to Congress is due December 31, 1995.

94-132 Study of Resource-Based Outpatient Facility Costs

Project No.:	17-C-90379/3
Period:	September 1994–September 1995
Funding:	$ 140,000
Award:	Cooperative Agreement
Principal Investigator:	Henry Miller, Ph.D.
Awardee:	Center for Health Policy Studies 9700 Patuxent Woods Drive Columbia, MD 21046
HCFA Project Officer:	Michael Henesch Division of Payment Systems

Description: This study will expand upon earlier work performed by the awardee in the Measurement of Outpatient Facility Resource Costs study to measure resource use and costs for a variety of outpatient procedures as categorized in the ambulatory patient groups classification system. A research design has been developed by the awardee that will include an examination of 42 high-volume procedures for which substantial variations in resource use were identified between outpatient settings as well as causes of variations in indirect costs across facilities. Three high-volume procedure combinations performed during a single visit will also be examined to measure the direct costs of the procedure combinations. In addition, the awardee will develop resource costs for immunization procedures to meet congressional expectations in implementing the Vaccine for Children Program. Although some immunization procedures were measured in the earlier study, these efforts were limited in terms of specific immunizations studied and the sample size. In this study, resource costs will be developed at a sufficient level of detail to be certain that the nature of resources used and the costs of each resource are identified. The study is expected to utilize the resource profile database from the earlier study except for the immunization profiles. For the immunization cost task, a sample of 90 clinics and physician offices will be selected for data collection of standardized immunization profiles for each site. Data for a sample of sites will be collected through visits for detailed onsite data collection. A technical advisory panel will be convened to review the findings.

Status: Data analysis has started on the high volume procedures. Site visits have started for the immunization component and are expected to be complete in November 1995. The report is due in February 1996.

91-080 Teaching Physicians and the Medicare Program

Project No.:	17-C-90015/1
Period:	September 1991–June 1996
Funding:	$ 463,765
Award:	Cooperative Agreement
Principal Investigator:	Janet B. Mitchell, Ph.D.
Awardee:	Center for Health Economics Research 300 Fifth Avenue, 6th Floor Waltham, MA 02154
HCFA Project Officer:	William Buczko, Ph.D. Division of Payment Systems

Description: Relatively little is known about teaching physicians, their practice organization, their billing patterns, and their cost to the Medicare program. This study will examine practice plans in 10 hospitals to determine how practice in teaching hospitals is organized. Also, Part A and Part B claims will be merged with Medicare Cost Report data to determine the total cost of physicians' services in teaching hospitals as well as the extent of double payment by physicians. These data also will be used to evaluate the impact of the Medicare fee schedule on teaching physicians and related effects on volume of services performed.

Status: Site visits to case study hospitals have been completed and described in reports for each site. A summary report of these findings, "Teaching Physicians and the Medicare Program: A Case Study," is available from the contractor. Analyses of cost report data and interns and residents data have been completed and presented in a draft report. An analysis of Part A and Part B claims in the merged Part A/Part B database has been presented in a draft report. Analysis of 1993 Part A data began in September 1994. Problems in obtaining full Part B claims for 1992 and 1993 Part B claims have delayed the final data analyses for this project. These analyses should be completed by April 1996.

95-046 Understanding Properties of the Unique Physician Identification Number (UPIN) for Claims-based Research

Project No.:	500-92-0020DO14
Period:	August 1995–August 1996
Funding:	$ 161,642
Award:	Delivery Order in a Master Contract
Principal Investigator:	Killard W. Adamache, Ph.D.

Awardee:	Health Economics Research, Inc. (See page 206)
HCFA Project Officer:	Ann Meadow, Sc.D. Division of Payment Systems

Description: The Health Care Financing Administration (HCFA) assigns a single, national Unique Physician Identification Number (UPIN) to each physician who provides non-HMO services under the Medicare program. Originally mandated by Congress to safeguard program funds, the UPIN has growing potential as a research tool for studies of health manpower, access to care, payment methods, provider behavior, and other health services research issues. The purposes of this delivery order are to (1) investigate the strengths and limitations of the UPIN as a research tool—one which has been implemented within a complex, decentralized administrative system oriented primarily to health care claims processing; (2) improve and extend the research-related properties of the UPIN in the future; and (3) develop background information for supporting HCFA's move to a national electronic claims-processing and practitioner/supplier enumeration system. The project tasks include analyzing data from claims and physician-enumeration files; gathering background information on carrier operations that have significance for interpreting UPIN-related data; conducting discussions with selected State licensing boards about license number assignment and technologies with potential to support license verification procedures; and developing methods to recover missing UPINs on the 1991 National Claims History File.

Status: This project is in the early development stage.

93-044 **Unique Physician Identification Number Validation Studies** (Formerly, Uniform Physician Identifier Number Validation Studies)

Project No.:	500-92-0020DO05
Period:	June 1993–July 1994
Funding:	$ 151,862
Award:	Delivery Order in Master Contract
Principal Investigator:	Killard W. Adamache, Ph.D.
Awardee:	Health Economics Research, Inc. (See page 206)
HCFA Project Officer:	Ann Meadow, Sc.D. Division of Payment Systems

Description: This project researched methods for improving the reliability and validity of the Unique Physician Identification Number (UPIN) and related data. Under a congressional mandate, a UPIN is assigned to each Medicare physician. UPIN system records contain basic professional characteristics data on each assignee. The UPIN system offers a tool for improving administrative functions such as developing new payment policies, monitoring impacts of policy changes, and uncovering fraud and abuse.

Status: This project has been completed. The awardee conducted site visits at six Medicare carriers and three health maintenance organizations (HMO); analyzed the characteristics and limitations of UPIN data elements nationally and for each carrier; developed computer programs and flow charts to describe the desired analytic and corrective procedures; designed and produced a series of record-specific reports to aid carriers in retrospectively correcting UPIN records; and produced several estimates addressing additional issues of physician enumeration. Analysis of the integrity of UPIN data elements covered all 1.68 million active practice-setting records (representing 657,000 physicians) in the UPIN system as of July 1993. It revealed that for each of four key data elements—date of birth, professional school code, graduation year, and State license number—the proportion of records with missing, erroneous, dubious, or unknown values was 10 to 15 percent. Integrity measures for individual variables were poorest for practice-setting records submitted in 1989, the first year of UPIN Registry operations. There was considerable variation in data element integrity by carrier. The prevalence of conflicting data within an individual practice-setting record generally did not exceed 5 percent for any given comparison (e.g., conflict between physician's specialty and credential). Among the 271,635 physicians with multiple practice-setting records containing feasible values in the date of birth field, inconsistent information affected 4 percent. Similarly, with regard to graduation year and professional school code, about 5 percent of the physicians with multiple, feasible values for each data element had an inconsistency. Findings from the various enumeration analyses included: Some 2,200 or more physicians have been assigned more than one UPIN. There are no apparent instances in which a UPIN has been inadvertently assigned to a medical group or corporation. The number of HMO physicians who treat Medicare beneficiaries but do not have a UPIN is estimated to be only 3,069 nationally, or 20 percent of HMO Medicare physicians. Finally, enumeration of the physicians electing to join the Medicare Participating Physician Program, based on Registry data, departs markedly from results obtained using the National Claims History. The five deliverables produced under this contract are available from National Technical Information Service:

- "Unique Physician Number (UPIN) Validation Studies: Carrier Analysis," PB95-138806, describes the characteristics and limitations of UPIN data elements nationally and by carrier.
- "Unique Physician Number (UPIN) Validation Studies: Carrier Edits," PB95-138780, provides computer programs and flow charts describing analytic and corrective procedures for carriers.

- "Unique Physician Number (UPIN) Validation Studies: Researcher Edits," PB95-138772, provides computer programs and flow charts describing analytic and corrective procedures for researchers.
- "Unique Physician Number (UPIN) Validation Studies: Documentation for the UPIN Integrity and Multiple UPIN Files," PB95-137881, describes the use of computer programs that produce a series of record-specific reports to assist carriers in retrospectively correcting UPIN records.
- "Unique Physician Number (UPIN) Validation Studies: Final Report," PB96-112891, presents the Executive Summary of the project, a report on the UPIN operations of the Registry contractor and of the six case-study carriers, and results of the following analyses: estimates of the number of HMO physicians without UPINs who treat Medicare beneficiaries, inadvertent assignment of UPINs to group practices and corporations, and consistency of Medicare Participating Physician status in the Registry data and National Claims History file.

Intramural

IM-040 A Comparative Analysis of Formulas Used by Medicaid and Private Payers to Reimburse Pharmacists for Outpatient Prescription Drugs

Funding: Intramural
HCFA Project Director: Kathleen Gondek, Ph.D.
Division of Payment Systems

Description: The objective of this study was to compare and contrast insurance plan characteristics and payment formulas used by Medicaid and private third party payers to reimburse pharmacies for outpatient prescription drugs. Information obtained included the geographic area served, total number of enrollees, cost-containment provisions, claims processing methods and payment formulas. A market basket of 25 drugs was randomly selected from the top 100 drugs by dollar rank from Medispan for the last quarter of 1993 to illustrate the impact of payment formulas on reimbursement. The payment formulas used by a total of 95 plans, 45 private and 50 Medicaid were examined. The plans were ranked on the generosity of their formulas.

Status: A draft report has been received and is currently under review.

IM-039 Assessment of Competitiveness in the Health Care Product Industries

Funding: Intramural
HCFA Project Director: Jay Bae, Ph.D.
Division of Payment Systems

Description: As a reimbursement methodology, the competitive pricing (bidding) model has important advantages over the retrospective reimbursement method and fee schedules. The competitive pricing has strong incentive for efficiency unlike the cost-based retrospective reimbursement method, but it requires little knowledge about cost structures of the suppliers, contrary to the fee schedule method.

Despite the advantages, this method cannot always be relied on for a prudent reimbursement amount. In order for this method to be effective, it is essential that a critical level of competition exists among the potential bidders in the industry. Otherwise, excessive payment amounts could result, as the method is, in essence, paying on the supplier's offer.

The objective of this study is to assess the degrees of competition in the health care product industries, and identify the sectors that can best support the competitive pricing paradigm. The first phase of the project is to appraise the level of competition in the standardized health care products (as opposed to customized products or services) that can be sold across the geographic areas. The health care sectors will be compared with non-health care sectors.

Status: This project is in an early stage.

IM-005 Financial Ratios: Implications for Assessment of Hospital Profitability and Efficiency

Funding: Intramural
HCFA Project Director: William Buczko, Ph.D.
Division of Payment Systems

Description: This project examines the utility of financial ratios for assessment of hospital financial status and compares several ratios measuring aspects of financial performance using Medicare Cost Report data.

Status: Analysis of Medicare patient margin and total facility margin data to assess hospital profitability is ongoing. "Non-Patient Revenue and Hospital Diversification," a paper examining the effect of non-patient revenue sources on hospital organization and performance, was presented at the 1994 Annual Meeting of the American Public Health Association. Further research will examine additional financial indicators using updated cost report data.

IM-008 **Malpractice Component of the Medicare Economic Index**

Funding: Intramural
HCFA Project Director: Benson L. Dutton, Division of Payment Systems

Mandate: Social Security Amendments of 1972 (Public Law 92-603)

Description: Each year since 1975, the Health Care Financing Administration (HCFA) publishes the Medicare Economic Index (MEI), which was first mandated by Congress in Public Law 92-603 for use in establishing reasonable charges for physician services. Since 1992, the MEI has been used as a key factor in determining the Medicare fee schedule's annual conversion factor update pursuant to section 6102(a) of Public Law 101-239. The MEI is developed by HCFA's Office of the Actuary in accordance with the basic methodology set forth in 42, *Code of Federal Regulations* 405.504(a)(3)(i) and 405.504(d) from selected components of the Consumer Price Index and the Producer Price Index, plus estimates of the annual changes in medical malpractice premiums for specific levels of coverage. HCFA's Office of Research and Demonstrations collects data for calculating the malpractice component of the MEI annually from major medical malpractice insurers. For several periods beginning January 1, 1987, the MEI increase has been established by Congress through section 9331(c)(i) of Public Law 99-509 for fee screen year (FSY) 1987, and section 4041(a) of Public Law 100-203 for the first 3 months of FSY 1988, and section 4042(b)(4)(F)(iii) for FSY 1989, and section 4105(a) of Public Law 101-508 for FSY 1991 and FSY 1992. Again, for FSY 1994 and FSY 1995, changes in the physician fee schedule conversion factor and the Medicare volume performance standards update factor were established under sections 13511 and 13512 of Public Law 103-66 respectively.

Status: The requisite data for updating the medical malpractice component of the MEI have been obtained and results provided to HCFA's Office of the Actuary. Announcement of the next MEI will be made in the *Federal Register* for FSY 1996 (January 1, 1996 to December 31, 1996).

IM-043 **Physician Behavioral Response to Fee Changes**

Funding: Intramural
HCFA Project Directors: Ann Meadow, Sc.D., Jesse Levy, Ph.D., and Edgar A. Peden, Ph.D., Division of Payment Systems

Description: Using physician-level claims data, this project will investigate Medicare physician behavior in the face of fee changes, primarily those implemented under the Medicare Fee Schedule. Dependent variables will include the physician's supply of selected categories of services, physician caseload, and Medicare Participating Physician/assignment rates. The dependent variables of interest concern services provided to Medicare beneficiaries, but the study will control for several important influences on physicians' practice, including private insurance fees for physician services and beneficiaries' demand for care.

Status: This project is in the early developmental stage.

IM-041 **Physician Practices' Responses to Changes in Fees**

Funding: Intramural
HCFA Project Directors: Edgar A. Peden, Ph.D. and Jesse M. Levy, Ph.D., Division of Payment Systems

Description: This project is being done to support the work of developing practice cost-relative value units (RVUs) for Medicare. Currently the project includes three studies. The first examines physician practices' volume responses to overall changes in fees. Most studies up to now have viewed these responses in a short run manner wherein physician practices increase the volume of services to make up for lost income when fees decrease and decrease the volume of services when fees increase. This study posits that this phenomenon may be strictly short run and that the volume–after the initial change–will revert to the level it would have been without the fee changes. Data from the American Medical Association is then used to test this hypothesis. The second study investigates whether physicians' practice costs are a function of the fees they receive. Up to now, the proposed approaches to reimbursing practice costs for the Medicare program have centered around measuring and covering current costs on a procedure-by-procedure basis. This study shows that if fees themselves affect practice costs, this should be taken into account in setting fees that are both efficient (lowest cost) but that cover the practice costs that the practices adapt to rather than simply the current average costs. Again, American Medical Association data is being used to study the effect of fees on practice costs. The third study will incorporate what is found in the above two studies together with data from the Abt study, Data Collection and Analysis for Generating Procedure Specific Practice Expense Estimates (Contract No. 500-95-0009), to develop alternative RVUs for physicians' practice costs on a procedure-by-procedure basis. This will include a scenario for setting RVUs based on an accounting methodology and a scenario which brings into play efficiency criteria.

Status: The first and second studies are currently being prepared; the third study is in an early formative stage.

IM-035 Revising the Medicare Geographic Practice Cost Index: Report to Congress

Funding: Intramural
HCFA Project Director: Sherry A. Terrell, Ph.D.
Division of Payment Systems

Mandate: 1994 Amendments to the Social Security Act (Public Law 103-432)

Description: The Secretary of Health and Human Services is required to study and report by October 31, 1995, on (1) data necessary to revise the Medicare Geographic Practice Cost Indexes (GPCIs), (2) limitations on the availability of data to revise such indexes, (3) ways of addressing such limitations, and (4) costs of developing more accurate data.

Status: The report to Congress has been completed and is in clearance within the Department. On the basis of the review, several methodological changes and newer and more comprehensive data were incorporated into the revised transition and the final indexes implemented on January 1, 1995, and January 1, 1996, respectively. See the Thursday, December 8, 1994, *Federal Register* 59(235):63410 for revised GPCI values. Data necessary to review and revise the GPCIs include practice expense data to calculate shares; Relative Value Units to calculate weights; and occupationally adjusted income data for professionals and health care workers, as well as rent data and malpractice expense data to calculate index values. The three major limitations on data availability are (1) the geographic coverage needed (breadth), (2) the geographic detail needed (depth), and (3) the frequency with which sources update data.

Since all necessary data are updated frequently enough to allow review and revision of index components at least every 3 years, except Census income data, efforts were concentrated on ways to address this data limitation. Not all data sources which might be used to update income data between decennial censuses could be fully evaluated by the report due date, therefore data will continue to be analyzed to determine the most useful for the GPCIs. Finally, the only data that might be more accurate than that which are currently used would require primary data collection, which is estimated by the Census Bureau to cost a minimum of $21 million for a one-time collection. Moreover, gathering primary data would not necessarily yield more accurate data than what is currently used.

IM-044 Utilization Patterns and Volume Stability at the Oncology Firm Level for Treatment of Medicare Beneficiaries with Cancer

Funding: Intramural
HCFA Project Director: Teresa DeCaro
Division of Payment Systems

Description: Patterns of care and volume stability at the physician organization level will be studied using per capita measures of utilization for selected oncology services and for all Medicare services. The effect of the principal provider organization's characteristics, size and case mix of oncology practice, and geographic location on per capita costs will also be examined. These analyses will support the development of alternative service bundles and carve out payments for the care of Medicare cancer patients. The Medicare-SEER database will be the principal source of data.

Status: This project is in an early development phase.

Extramural

95-068 A Better Chance Welfare Reform Project

Project No.:	11-W-00056/3
Period:	October 1995–October 2002
Funding:	Waiver only
Award:	Waiver-only Project
Principal Investigator:	Elaine Archangelo
Awardee:	Delaware Health and Social Services 1901 North DuPont Highway New Castle, DE 19720
HCFA Project Officer:	Alisa Adamo Office of State Health Care Reform Demonstrations

Description: A Better Chance Welfare Reform Demonstration is designed to test a set of provisions that will link opportunity and responsibility, support the formation and maintenance of two-parent families, provide positive incentives for private sector employment, and reduce teenage pregnancy. It also institutes the development of a Contract for Mutual Responsibility for all recipient families, which will address requirements such as school attendance for children, immunizations, etc.

Some of the specific provisions in the demonstration are: a 2-year time limit for most families to move to economic self-sufficiency; the provision of Aid to Families with Dependent Children (AFDC) benefits after 2 years through a pay-after-performance work experience component; a requirement for weekly job search during the second 2-year period; and stronger sanctions for noncompliance with education- and employment-related provisions of the contract, which result in progressive reductions in AFDC benefits and potentially, a whole-family sanction.

To reinforce these work and education requirements, the State is providing some additional benefits, such as an additional year of transitional Medicaid and transitional child care. Medicaid waivers were required to provide demonstration recipients 12 additional months of transitional Medicaid if their income is under 100 percent of the Federal poverty level.

Status: The State began operations on October 1, 1995.

95-064 A JOBS First Strategy

Project No.:	11-W-00042/2-01
Period:	April 1995–April 2000
Funding:	Waiver only
Award:	Waiver-only Project
Principal Investigator:	Michael J. Dowling
Awardee:	New York State Department of Social Services 40 North Pearl Street Albany, NY 12243-0001
HCFA Project Officer:	Maria Boulmetis Office of State Health Reform Demonstrations

Description: In six sites, waivers permit the State to provide payments and loans for one-time emergencies to avoid eventual welfare dependence; modify allowable work experience, job training, and other employment activities in addition to job search services for Aid to Families with Dependent Children (AFDC) and Food Stamp applicants and recipients; consolidate and streamline Food Stamp and AFDC eligibility requirements; permit development of a pay-for-performance system; provide incentives for children to attend school; make unemployed noncustodial parents of children on AFDC eligible for Jobs Opportunity and Basic Skills (JOBS) training programs; expand and broaden eligibility for a child assistance program (a previous welfare reform demonstration providing incentives for employment and the collection of child support); require minors to live at home; require participation in JOBS for unemployed noncustodial parents of children on AFDC; give a 12-month transition benefit with no income limit, with health insurance status ascertained at the beginning and end of the transition period.

Status: The State has indicated that this project may not be implemented.

95-095 Access in Managed Care

Project No.:	500-95-0048/TO2
Period:	September 1995–March 1997
Funding:	$401,389
Award:	Contract
Principal Investigator:	Margo Rosenbach and Debra Dayhoff
Awardee:	Health Economics Research

(See page 211)

HCFA Project Officer:	Renee Mentnech Division of Health Information and Outcomes

Description: The purpose of this project is to develop a framework for measuring access in managed care using encounter level data. This framework will then be tested with actual data from the Harvard Community Health Plan in Boston.

Status: The project is in the developmental phase. The contractor is conducting a literature review and will be presenting a proposed design at the first Technical Expert Panel meeting in January 1996.

92-014 Access to Care in the Medicaid Program

Project No.:	18-C-90134/3
Period:	February 1992–October 1994
Funding:	$ 253,118
Award:	Cooperative Agreement
Principal Investigator:	Jack Hadley, Ph.D.
Awardee:	Georgetown University Center for Health Policy Studies 2233 Wisconsin Avenue, NW., Suite 525 Washington, DC 20007
HCFA Project Officer:	M. Beth Benedict, Dr. P.H. Division of Health Information and Outcomes

Description: This study addressed two research questions: Did Medicaid-enrolled and uninsured women and children have the same access to care as did the privately insured? How did variations in Medicaid policies and potential access barriers affect the use of services?

Status: Georgetown University is preparing the final report. Differences in access to care were inferred from analyses of four sets of access indicators that were constructed from hospital discharge data: admissions for ambulatory-care-sensitive conditions (i.e., preventable or avoidable hospitalizations); admissions for diagnoses and use of procedures, given a diagnosis for which medical necessity is relatively clear-cut; admissions for diagnoses and use of procedures for which medical necessity is less clear or for which there is greater discretion from the physician's perspective; and outcomes of care. Data between 1986 and 1990 from up to 15 States were pooled and used in the analyses.

92-095 Access to Medicare Physician Services

Project No.:	17-C-90044/3
Period:	March 1992–December 1995
Funding:	$ 710,421
Award:	Cooperative Agreement
Principal Investigator:	Stephen Zuckerman, Ph.D.
Awardee:	The Urban Institute 2100 M Street, NW. Washington, DC 20037
HCFA Project Officer:	Paul W. Eggers, Ph.D. Division of Health Information and Outcomes
Mandate:	Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239)

Description: This cooperative agreement comprises three tasks related to Medicare beneficiary access to physician services. Task 1 involves measuring trends in the volume and intensity of Medicare physician services. Task 2 involves the analysis of the relationship between pricing policies and access to Medicare physician services. Task 3 uses the 1992 Medicare Current Beneficiary Survey (MCBS) to study beneficiary access to physician services.

Status: Analyses under Task 1 (i.e., tracking changes in the volume and intensity of physician services between 1985 and 1990 using relative value units) have been completed. Estimates of changes using this system are lower than earlier estimates by the Urban Institute using a price index approach. This suggests that the price index approach may have underestimated price growth, thus overstating volume and intensity growth. Sample design, including selection of physician specialties has been completed for Task 2. Econometric analyses on this task have begun. Task 3 is an analysis of access using the MCBS. Results are expected by the end of calendar year 1995.

95-047 Arizona Welfare Reform: Employing and Moving People off Welfare and Encouraging Responsibility Program (EMPOWER)

Project No.:	11-W-00058/7
Period:	November 1995–October 2002
Funding:	Waiver only
Award:	Waiver-only Project
Principal Investigator:	Linda Blessing
Awardee:	Arizona Department of Economic Security P.O. Box 6123 Phoenix, Arizona 85005
HCFA Project Officer:	Joan Peterson Office of State Health Reform Demonstrations

Description: Statewide, the demonstration will not increase benefits for additional children conceived while the mother is receiving Aid to Families with Dependent Children (AFDC); will limit benefits to adults to 24 months in any 60-month period; will allow recipients to deposit up to $200 per month (with 50 percent disregarded) in Individual Development Accounts; will require minor mothers to live with parents; will extend transitional child care and Medicaid to 24 months; and will eliminate the 100-hour rule for Aid to Families with Dependent Children-Unemployed Parent (AFDC-UP) cases. In a pilot site, the demonstration will provide individuals with short-term public or private on-the-job training subsidized by grant diversion, which includes cashing-out food stamps.

Status: This project is in the early implementation stage.

93-065 **Assessment of the Impact of Medicaid Drug Rebate Policy on Expenditures, Utilization, and Access** (Formerly, Impact of the Medicaid Drug Rebate Policy on Expenditures, Utilization, and Access)

Project No.:	500-92-0022DO03
Period:	September 1993–June 1994
Funding:	$ 339,848
Award:	Delivery Order in Master Contract
Principal Investigator:	Jon Christianson, Ph.D.
Awardee:	University of Minnesota (See page 209)
HCFA Project Officer:	Kathleen Gondek, Ph.D. Division of Payment Systems

Description: The purpose of this study is to assess the impact of the Medicaid drug rebate program on expenditures, utilization, and access to medications for Medicaid recipients. The study will use a decomposition analysis to determine the change in total drug expenditures before and after implementation of the Medicaid drug rebate program. The role of covered population changes, intensity (utilization rate) changes, changes in efficiency (drug product prices), changes in dispensing fees and changes in rebates, and administrative costs will be evaluated. The impact on recipient access will be assessed by constructing a person-level file of prescription drug claims both pre- and post-Omnibus Budget Reconciliation Act of 1990 (legislation that mandated the drug rebate program).

Status: "Impact of the Medicaid Drug Rebate Program on Expenditures, Utilization and Access: Final Report," is complete. A copy of the full report is available through the National Technical Information System, accession number, PB96-221594.

93-005 **California Welfare Reform: Assistance Payments Demonstration Project** (Formerly, California Assistance Payment Demonstration)

Project No.:	11-W-00018/9
Period:	December 1992–November 1997
Funding:	Waiver only
Award:	Waiver-only Project
Principal Investigator:	Eloise Anderson
Awardee:	California Department of Social Services 744 P Street Sacramento, CA 95814
HCFA Project Officer:	Joan Peterson Office of State Health Reform Demonstrations

Description: This demonstration originally had waivers from the Administration for Children and Families (ACF) that removed the time limitation on the disregard of earnings of recipients of Aid to Families with Dependent Children (AFDC) and removed the limitation on hours of work in two-parent families in California. Subsequent ACF waivers were added, permitting the State to give teenage parents bonuses/penalties in the AFDC grant payment for grade averages above/below certain levels; increasing resource limitations and disregarding restricted savings accounts; implementing certain changes in the Job Opportunities and Basic Skills program required under Federal law; and allowing recipients with earned income to choose child care assistance in lieu of a cash grant. In conjunction with this demonstration, the State decreased the welfare payment. The Health Care Financing Administration (HCFA) granted a maintenance of effort waiver, permitting the approval of State Medicaid plans, even though the AFDC payment level was below the level in effect on May 1, 1988. HCFA also authorized the State to maintain the eligibility level of its medically needy program, making the medically needy eligibility level more than 133 1/3 percent of the lowered AFDC payment level.

Status: The reduction in AFDC benefits was contested, and the Ninth Circuit Court of Appeals vacated HCFA's "maintenance of effort" waiver (*Beno* v. *Shalala*). In July 1994, the court remanded the case to the Secretary of the Department of Health and Human Services for additional consideration. The State has since applied to make some groups exempt from benefit cuts, in line with the arguments and opinions expressed in the *Beno* lawsuit. However, no changes have been approved, pending the resolution of *Beno*.

91-058 Center Billings for Ancillary Dialysis Services

Project No.:	99-C-98489/9
Period:	August 1991–July 1993
Funding:	$ 120,000
Award:	Cooperative Agreement
Principal Investigator:	Joel D. Kallich, Ph.D.
Awardee:	The RAND Corporation Health Sciences Program 1700 Main Street, P.O. Box 2138 Santa Monica, CA 90407-2138
HCFA Project Officer:	Joel W. Greer, Ph.D. Division of Health Information and Outcomes

Description: Medicare pays a fixed (composite) rate for each dialysis session including supplies, drugs, and tests. There are ancillary services that could be considered as part of the dialysis session but may be billed separately at times. This study has compiled a list of these ancillary services and has examined the current quantity and costs of supplies, drugs, laboratory tests, and radiology services provided to dialysis patients supplementary to those covered in the composite rate.

Status: A final report has been received and is currently under review.

94-077 Changes in Population Characteristics and Medicaid Utilization/Expenditures Among Children and Adolescent Supplemental Security Income Recipients

Project No.:	18-C-90455/1
Period:	September 1994–September 1996
Funding:	$ 581,035
Award:	Cooperative Agreement
Principal Investigator:	James Perrin, M.D.
Awardee:	Massachusetts General Hospital Children's Service Fruit Street, WACC 715 Boston, MA 02114
HCFA Project Officer:	Feather Ann Davis, Ph.D. Division of Aging and Disability

Description: The Supplemental Security Income (SSI) program for children and adolescents has expanded in the past 5 years as a result of new Social Security Administration (SSA) guidelines for determining disability caused by mental impairments, new guidelines for determining childhood disability in general, and major outreach efforts by SSA to identify children with disabilities. The project has four main objectives:

- Determine the current clinical characteristics of child and adolescent SSI recipients and the changes in these characteristics during the period of program expansion that began in the late 1980s.
- Determine patterns of Medicaid utilization and expenditures among important clinical subgroups and examine changes in these patterns during the period of program expansion.
- Examine the utilization trajectories and clinical characteristics of certain SSI recipient groups over time, including recipients with high-cost physical conditions such as cystic fibrosis, congenital heart disease, and spina bifida, and high-prevalence, low-cost conditions such as attention deficit disorder, hyperactivity, and learning disabilities.
- Determine the degree to which new recipients reflect shifting among Medicaid eligibility categories and the coverage and use of other insurance after getting SSI.

Status: Data files have been constructed, and preliminary data tables have been run.

94-071 Colorado Welfare Reform: Personal Responsibility and Employment Program

Project No.:	11-W-00009/8
Period:	November 1993–October 1997
Funding:	Waiver only
Award:	Waiver-only Project
Principal Investigator:	Barbara McDonnell
Awardee:	Colorado Department of Human Services 1575 Sherman Street Denver, CO 80203-1714
HCFA Project Officer:	Maria Boulmetis Office of State Health Reform Demonstrations

Description: This demonstration has waivers from the Health Care Financing Administration, the Administration for Children and Families, and the Department of Agriculture (Food Stamps) to do the following:

- Consolidate the Aid to Families with Dependent Children (AFDC) grant, Food Stamps, and child care benefits into a single cash payment.
- Impose AFDC financial sanctions on families if children under 2 years of age are not immunized or employable adults are noncooperative after 2 years.
- Increase disregards of earnings and assets and provide financial incentives to participants who graduate from high school or who obtain a high school equivalency.

- Allow cases that have been on AFDC for less than 3 of the previous 6 months to receive the Medicaid transition benefit, if they lose AFDC eligibility because of earnings and eliminate quarterly income reporting during the transition period, reporting only income increases.

Status: The State is continuing to implement the demonstration.

92-058 Comparative Study of the Use of Early and Periodic Screening, Detection, and Treatment and Other Preventive and Curative Health Care Services by Children Enrolled in Medicaid

Project No.:	500-92-0066
Period:	September 1992–August 1995
Funding:	$ 1,262,400
Award:	Contract
Principal Investigator:	Norma Gavin, Ph.D.
Awardee:	SysteMetrics, Division of MedStat, Inc. 777 East Eisenhower Parkway, Suite 500 Ann Arbor, MI 48108
HCFA Project Officer:	Feather Ann Davis, Ph.D. Division of Aging and Disability

Description: The contract comprises a series of research projects designed to do the following:

- Study the effect of the changes in the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program introduced by the Omnibus Budget Reconciliation Act of 1989 on the process of providing health services to children and on the appropriateness of expenditures for the services provided in Tennessee, Georgia, Michigan, and California.
- Compare Medicaid-enrolled children in four EPSDT programs with other Medicaid-enrolled children in the four States who are not receiving EPSDT services, regarding enrollment patterns, service utilization, and expenditures, with a particular emphasis on preventive health services.
- Compare Medicaid-enrolled children with non-Medicaid-enrolled children, insured and uninsured, on the use of and expenditures for preventive services and other health care services, using national survey data.

Status: The site visits and the 1989 analyses have been completed; the 1992 data analyses are underway. Reports submitted include the following:

- Adams, E.K., and Graver, L.: "Analysis of Medicaid Provider Supply Overall and for Preventive Care Services for Children, 1989," June 1994.
- Gavin, N.: "Review and Synthesis of the Literature on the Implementation and Effectiveness of Recent Legislative Initiatives Relating to Medicaid and EPSDT Coverage for Children," December 15, 1992.
- Gavin, N., and Bencio, D.S.: "Comparison of Access to Care Among Medicaid and Other Groups of Children: 1982 and 1988 National Health Interview Surveys." November 23, 1993.
- Herz, L., Gavin, N., Ellwood, M., and Sredl, K.: "The Use of EPSDT and Other Health Care Services by Medicaid Children, 1989." May 3, 1994.
- Hill, I. and Zimmerman, B.: "Evaluation of EPSDT Programs in the Tape-To-Tape States: Volume I: Synthesis of EPSDT Case Study Reports," May 3, 1995.
- Hill, I. and Zimmerman, B.: "Evaluation of EPSDT Programs in the Tape-to-Tape States: Volume II: Case Study Reports."
- Gavin, N.: "The Impact of Medicaid on Children's Health Service Use and Expenditures: 1987 National Medical Expenditure Survey." October 12, 1995.

94-069 Connecticut Welfare Reform: A Fair Chance

Project No.:	11-W-00022/1
Period:	October 1994–September 2001
Funding:	Waiver only
Award:	Waiver-only Project
Principal Investigator:	Joyce A. Thomas
Awardee:	Connecticut Department of Social Services 25 Sigourney Street Hartford, CT 06106-5033
HCFA Project Officer:	Joan Peterson Office of State Health Reform Demonstrations

Description: Statewide, the demonstration will expand Aid to Families with Dependent Children-Unemployed Parent (AFDC-UP) eligibility; change filing unit requirements; increase motor vehicle and asset limits; eliminate the 185 percent of need test; disregard student earnings; increase earned income disregards; redirect support payments to the AFDC family; extend transitional child care and Medicaid benefits; and include several jobs program changes. In the pilot sites, the demonstration requires work activity after 2 years of AFDC, eliminates most jobs exemptions, and establishes a child support assurance program.

Status: In October 1994, Connecticut began implementing the reforms embodied in A Fair Chance. The State proposed modifications to A Fair Chance in August 1995, which are currently under review. Statewide, these amendments would establish time limits; disregard earnings for time-limited recipients up to the poverty level; reduce the benefit increase for additional children by one-half; require minor

parents to live with an adult; change redetermination, verification, and reporting requirements; provide employer tax credits for hiring AFDC recipients; require biometric identification as a condition of eligibility; establish a two-tier payment system for new residents; simplify and conform AFDC and Food Stamp rules on resources; change JOBS sanctions; extend transitional Medicaid to 2 years; and several other provisions. In addition, Connecticut requested a waiver from Health Care Financing Administration to maintain their medically needy income level at the pre-July 1995 level despite a reduction in the AFDC payment standard.

92-045 Cost-Containment Measures for Physician and Other Services

Project No.:	500-89-0052
Period:	August 1992–November 1993
Funding:	$ 71,957
Award:	Contract
Principal Investigator:	Suzanne Felt
Awardee:	Mathematica Policy Research, Inc. 600 Maryland Avenue, SW. Suite 550 Washington, DC 20024-2512
HCFA Project Officer:	Herbert A. Silverman, Ph.D. Division of Payment Systems
Mandate:	Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: The awardee conducted a survey of all State Medicaid agencies concerning their utilization management activities, including ambulatory surgery, preadmission testing, same-day surgery, primary care or other case management, preadmission certification, lock-in, rebundling, and second surgical opinion. The objective of the survey was to determine which States have which types of programs; the characteristics of the programs, including target populations, subject procedures, and payment issues; and the evidence and opinions States have as to the effects of each of the programs on access to necessary care, quality of care, and costs of care.

Status: Mathematica has submitted a report of its survey findings and a review of the literature. A Report to Congress has been drafted and is undergoing administrative review at the Health Care Financing Administration. Release of the Report to Congress is anticipated to be in early 1996.

93-007 Delaware Health Care Partnership for Children

Project No.:	11-P-98235/3
Period:	January 1993–June 1996
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Philip Soule
Awardee:	Delaware Department of Health and Social Services 1901 North DuPont Highway New Castle, DE 19720
HCFA Project Officer:	David W. Walsh Office of State Health Reform Demonstrations

Description: The Delaware Medicaid-Managed Care Demonstration is a public-private initiative between the State of Delaware and the Alfred I. duPont de Nemours Foundation (Nemours). Nemours has pledged to develop and maintain 13 pediatric practices/clinics, known as Children's Clinics, in the underserved areas of Delaware. Delaware will enroll Medicaid-eligible children, under 17 years of age, in the clinics on a capitated basis for up to 1 year. Each clinic will operate like most pediatric/family practices. The clinics will be staffed by board-certified pediatricians, pediatric nurse practitioners, and nursing and office support personnel. Children in all three counties of the State will receive a basic benefit package that includes physician office visits; early and periodic screening, diagnosis, and treatment services; basic lab tests; and certain pharmaceuticals. Only those eligibles living in New Castle county, where the Alfred I. duPont Institute (a pediatric hospital) is located, will have their hospital expenses covered under the capitation.

Status: The State began operations in December 1993. As of September 1995, 6,600 children had been enrolled in the project, and 10 children's clinics had been opened. As of June 30, 1996, this project will be folded into Delaware's statewide managed-care demonstration, entitled the "Diamond State Health Plan."

92-067 Demonstration Project on Drug Use Review in Medicaid: Online Prospective Drug Utilization Review

Project No.:	11-C-90232/7
Period:	September 1992–December 1996
Funding:	$ 1,787,153
Award:	Cooperative Agreement
Principal Investigator:	Betsy Chrischilles, Ph.D.

Awardee:	State of Iowa Division of Medical Services East 13th and Walnut Hoover Building, 5th Floor Des Moines, IA 50319
HCFA Project Officer:	Kathleen Gondek, Ph.D. Division of Payment Systems
Mandate:	Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: The purpose of the demonstration is to test the effect of an online prospective drug utilization review system. Iowa will develop and test the system over a 15-month period, followed by a 3-year operational phase. Analyses will address the impact of this intervention on quality of care and on use and costs of prescription drugs and other services. Iowa will test the effect of the system with experimental and control groups via a randomized block design assigning clusters of pharmacies to either intervention or control groups. Iowa has assessed the computer capabilities of State pharmacies and has developed the prospective drug utilization review screens.

Status: This project was implemented in June 1994. To date approximately 10 percent of all prescription drug claims generate a drug utilization review message.

95-026 Design Contract for the Medicare Beneficiary Health Status Registry

Project No.:	500-95-0060
Period:	October 1995–July 1996
Funding:	$ 458,824
Award:	Contract
Principal Investigator:	Kirk Pate
Awardee:	Research Triangle Institute P.O. Box 12194 Research Triangle Park, NC 27709
HCFA Project: Officer:	Leslye Fitterman, Ph.D. Division of Health Information and Outcomes

Description: The purpose of this contract is to develop features of a new system entitled "The Medicare Beneficiary Health Status Registry," which is designed to monitor and evaluate the health status of Medicare beneficiaries throughout their enrollment in the program. The Registry will collect information from beneficiaries that is not in the administrative claims, link the information to claims and provide a longitudinal database for studies to inform policy decisions concerning health care coverage, payment, financing, and delivery systems. The goals of the project encompass three broad areas: a sample design, questions to be included in the questionnaires, and survey procedures. The findings from the Registry pilot study, completed in 1994, suggest that the Registry design—a mailed questionnaire and telephone followup—is feasible. Reliable and accurate information about functional status, quality of life, health behaviors, and prior medical history can be collected across all age groups. A panel composed of experts in health services research, health status measurement, sampling design, and survey design will advise Research Triangle Institute and the Health Care Financing Administration.

Status: The contract was awarded in September 1995.

94-088 Design of a Cost-Effectiveness Protocol for the Morbidity and Mortality in Hemodialysis Clinical Trials

Project No.:	500-92-0023DO07
Period:	December 1993–October 1995
Funding:	$ 160,752
Award:	Delivery Order in Master Contract
Principal Investigator:	Anthony Bower, Ph.D.
Awardee:	The RAND Corporation (See page 208)
HCFA Project Officer:	Joel W. Greer, Ph.D. Division of Health Information and Outcomes

Description: The project is developing the research protocol, the methodology and the data collection instruments, and the manuals necessary for a cost-effectiveness analysis of the morbidity and mortality in hemodialysis (MMHD), multicenter, randomized clinical trials. The MMHD clinical trial is testing the efficacy of two different interventions on the hemodialysis prescription—the use of high-flux dialyzers and an increase in the quantity of dialysis, as measured by double pool kinetic modeling. RAND will provide methods and instruments for measuring and estimating the cost of hemodialysis and all other medical services to the population in each of the treatment arms of the MMHD clinical trial, instruction manuals and training, and a cost-effectiveness study protocol.

Status: RAND has submitted the final report containing a pilot-tested data collection protocol. The report is currently under review.

94-075 Development of a Global Quality Assessment Tool for Managed Care

Project No.:	18-C-90315/9
Period:	September 1994–September 1997
Funding:	$ 1,579,386
Award:	Cooperative Agreement
Principal Investigator:	Elizabeth McGlynn, Ph.D.

Awardee:	The RAND Corporation 1700 Main Street P.O. Box 2138 Santa Monica, CA 90407-2138
HCFA Project Officer:	M. Beth Benedict, Dr. P.H. Division of Health Information and Outcomes

Description: This project will develop and test a clinically based method for assessing the quality of care delivered for a broad range of services in managed care health plans. It will focus on the quality of care delivered to children and to women under 45 years of age.

Status: The project has identified the quality of care indicators and is in the process of organizing the panels of experts.

92-018 Dialyzer Reuse: A Cohort Study

Project No.:	18-C-90045/3
Period:	February 1992–December 1996
Funding:	$ 476,716
Award:	Cooperative Agreement
Principal Investigator:	Harold I. Feldman, M.D.
Awardee:	The University of Pennsylvania School of Medicine Philadelphia, PA 19104-6095
HCFA Project Officer:	Joel W. Greer, Ph.D. Division of Health Information and Outcomes
Mandate:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509)

Description: The study is to determine the impact of reusing hemodialyzer membranes on the health status of end-stage renal disease patients undergoing chronic hemodialysis in the United States using the 1986–87 incident cohort. The study is using an intent-to-treat model based on reuse at the 91st day following initiation of dialysis therapy. The analysis uses proportional hazards modeling with patient survival as the primary outcome.

Status: The final analyses have been completed and draft paper for peer-reviewed publication prepared. A draft final report is expected in November 1995.

93-033 Drug Utilization Review Evaluation Contract

Project No.:	500-93-0002
Period:	March 1993–February 1998
Funding:	$ 4,604,856
Award:	Contract
Principal Investigator:	David Kidder, Ph.D.
Awardee:	Abt Associates, Inc. 55 Wheeler Street Cambridge, MA 02138
HCFA Project Officer:	Kathleen Gondek, Ph.D. Division of Payment Systems
Mandate:	Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: The purpose of this evaluation is to provide generalizable findings on the impacts of retrospective and prospective drug utilization review. Data from the two demonstration States (Iowa and Washington) and information on Medicaid drug utilization review activities from other States will form the basis of the evaluation findings. Maryland and Georgia will serve as coexperimental and comparison states. To test the effects of online prospective drug utilization review and of paying pharmacists for cognitive services on drug problems, drug use and costs, other health services' use and costs, and access to services will be measured. In addition, surveys to pharmacists and physicians will be conducted to assess changes in the behavior related to the demonstration's interventions.

Status: A Report to Congress describing the second year's activities has been completed. The final evaluation plan and preliminary analysis of the predemonstration period have been completed. The final report is due March 1998.

95-019 Durable Medical Equipment Supplier Product and Cost Study

Project No.:	500-95-0044
Period:	September 1995–May 1996
Funding:	$ 77,862
Award:	Contract
Principal Investigator:	G. Kowalczyk
Awardee:	Jing Xing Health and Safety Resources, Inc. 7008-K Little River Turnpike Annandale, VA 22003
HCFA Project Officer:	William J. Sobaski Division of Payment Systems
Mandates:	1994 Amendments to the Social Security Act, Section 135 (Public Law 103-432)

Description: Section 135 of the 1994 Amendments to the Social Security Act mandated that the Administrator of the Health Care Financing Administration (HCFA), in consultation with appropriate organizations: (1) collect data on supplier costs of durable medical equipment covered by

Medicare; (2) determine the proportions of costs attributable to the service and product components of furnishing such equipment; and (3) determine the extent to which these proportions vary by type of equipment and by geographic region. This project intends to assist HCFA in meetings with representatives of the durable medical equipment industry to obtain the data needed for this study.

Status: This new project is in the early development stage.

93-061 Economic and Cost-Effectiveness Studies for the U.S. Renal Data System

Project No.:	HCFA-IA-9305
Period:	July 1993–June 1998
Funding:	$ 1,657,075
Award:	Interagency Agreement
Principal Investigator:	Philip J. Held, Ph.D.
Awardee:	National Institute of Diabetes and Digestive and Kidney Diseases c/o Larry Agadoa, M.D. Building 31 31 Center Drive, MSC 2560 Bethesda, MD 20892-2560
HCFA Project Officer:	Joel W. Greer, Ph.D. Division of Health Information and Outcomes
Mandate:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509)

Description: This interagency agreement (IAA) provides funds to the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) to cover the cost of having the coordinating center for the U.S. Renal Data System (USRDS) perform economic and cost-effectiveness studies. NIDDK awarded a contract to the University of Michigan to be the coordinating center for 5 years from July 1993 to July 1998. The IAA calls for the coordinating center to conduct cost or cost-effectiveness components for at least four existing data studies and for one special study focused on economic issues each year.

Status: The coordinating center creates annual cost data sets. Two major ongoing studies are the (1) costs of providing dialysis based on dialysis facility annual cost report data and (2) cost-effectiveness study of vascular access techniques for hemodialysis. Sections on cost and cost-effectiveness were published in the 1995 USRDS *Annual Data Report*.

92-017 Economic Barriers to Access to Health Care Among the Elderly

Project No.:	17-C-90087/9
Period:	February 1992–October 1994
Funding:	$ 562,453
Award:	Cooperative Agreement
Principal Investigator:	Lee A. Lillard, Ph.D.
Awardee:	The RAND Corporation 1700 Main Street P.O. Box 2138 Santa Monica, CA 90407-2138
HCFA Project Officer:	Lawrence E. Kucken Division of Health Information and Outcomes

Description: The purpose of this project was to determine the degree to which economic barriers to health care exist within the elderly population. The study identifies socioeconomic subgroups among the elderly that may be more or less vulnerable to health services access problems and examines the relationship of health services use to economic status, insurance status, household structure, and sources of social support. Analyses are being performed using a database that links Medicare administrative records with the 1990 Health Supplement to the Panel Study of Income Dynamics.

Status: The analysis phase is nearly completed. The final report will focus primarily on factors affecting Medicare beneficiaries' possession of private supplementary health insurance and its effects on prescription drug and dental care use and expenditures.

92-025 Effects of Expanded Medicaid Coverage of Pregnant Women

Project No.:	18-C-90029/4
Period:	February 1992–February 1995
Funding:	$ 650,161
Award:	Cooperative Agreement
Principal Investigators:	Wayne A. Ray, Ph.D. Joyce M. Piper, Dr.P.H. (deceased)
Awardee:	Vanderbilt University School of Medicine 21st and Garland Nashville, TN 37232
HCFA Project Officer:	Herbert A. Silverman, Ph.D. Division of Payment Systems

Description: This study examines the effect of four Medicaid expansions in Tennessee: expanded eligibility for pregnant women and infants up to 100 percent of poverty (enacted July 1, 1987); presumptive eligibility (enacted February 1, 1989); enhanced prenatal care services (enacted July 1, 1989); and expanded eligibility for pregnant women and infants up to 150 percent of poverty (enacted January 1, 1990). Prenatal care use, birthweight, and infant mortality are the outcomes of interest. Data from Medicaid records, vital statistics, and the Risk Factor Surveillance

Program will be used to conduct both strata analysis and multivariate analysis to investigate the effect of each of the expansions separately and over one entire period of implementation.

Status: The findings of this study have been reported in the following papers:

- Piper, J.M., Mitchel, E.F., Jr., and Ray, W.A.: "Expanded Medicaid Coverage for Pregnant Women to 100 Percent of the Federal Poverty Level." *American Journal of Preventive Medicine*, Vol. 10, No. 2, 1994.
- Piper, J.M., Mitchel, E.F., Jr., and Ray, W.A.: "Presumptive Eligibility for Pregnant Medicaid Enrollees: Its Effects on Prenatal Care and Perinatal Outcome." *American Journal of Public Health*, Vol. 84, No.10, October 1994.
- Piper, J.M., Mitchel, E.F., Jr., and Ray, W.A.: "Evaluation of a Program for Prenatal Care Case Management." Unpublished.
- Ray, W.A., Mitchel, E.F., Jr., and Piper, J.M.: "Effect of Medicaid Expansions on Preterm Births." Unpublished.

The sum and substance of the findings are that the Medicaid expansions in Tennessee resulted in more poor women receiving prenatal care and receiving such care earlier in their pregnancy. This has resulted in a decrease in the proportion of women receiving inadequate prenatal care as measured by a modified Kessner Index. Despite these improvements in prenatal care, there has not been a discernible improvement in the incidence of low birthweight outcomes.

91-002 Emergency Room Triage Demonstration Report

Project No.:	95-P-99626/9
Period:	January 1991–March 1994
Funding:	$ 1,500,000
Award:	Grant
Principal Investigator:	Carter Clements, M.D.
Awardee:	Highland General Hospital 1411 East 31st Street Oakland, CA 94608
HCFA Project Officer:	Joseph M. Cramer Division of Payment Systems
Mandate:	Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239)

Description: In January 1991, the Health Care Financing Administration funded the first year of a 3-year emergency room triage demonstration. The explosive increase in demand for the services of Highland's emergency department has strained severely the resources of this inner city public hospital. The demonstration was mandated by section 6217 of the Omnibus Budget Reconciliation Act of 1989 that provided up to $500,000 in funding per year. Most of the funds have been used for hiring mid-level practitioners (MLPs) to treat patients needing only minimal services. In addition, patient advocates were hired to ease stress among patients and practitioners in this crisis-laden environment.

Status: The project was fully operational; the MLP triage team, the patient advocate team, and the evaluation group were in place and fully functional. The use of the MLPs has resulted in increased clinical coverage and patient care in the emergency room. The patient advocate team has produced significant results in reducing the level of tension and patient anger in the waiting room. Several studies on patient and staff satisfaction showed continuing increases in satisfaction with services received and delivered in the emergency department. Other studies showed a significant decrease in the average waiting time for patients to see the triage nurse. In addition, facility changes were made in the acute care clinic, which will provide better patient comfort and allow for more noncritical patients to be seen. A computer system was installed to establish a telephone followup protocol for results of previous visits for medical tests. Another computer system was installed that generates printed patient instructions that the patient can take home. The project has been completed.

92-021 End Stage Renal Disease Research Studies

Project No.:	17-C-90085/3
Period:	February 1992–June 1995
Funding:	$ 450,000
Award:	Cooperative Agreement
Principal Investigator:	Philip J. Held, Ph.D.
Awardee:	University of Michigan Kidney Epidemiology and Cost Center 315 West Huron, Suite 420 Ann Arbor, MI 48103
HCFA Project Officer:	Joel W. Greer, Ph.D. Division of Health Information and Outcomes
Mandate:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509)

Description: A no-cost extension until June 1996 is pending. The request is to allow publication of additional studies. The purpose of this project is to perform cost studies of major issues for the end stage renal disease program. Ongoing studies include an analysis of the dialysis facility cost reports, standardized hospitalization rates, and cost-effectiveness of different treatment modalities.

Status: Some papers funded in whole or in part have been published in professional journals:

- "Association of Dialyzer Reuse Practices and Patient Outcomes." *American Journal of Kidney Diseases.*
- "Effect of Race on Access to Recombinant Human Erythropoietin in Long-Term Hemodialysis Patients." *Journal of the American Medical Association.*
- "The Impact of HLA Mismatches on the Survival of First Cadaveric Kidney Transplants." *New England Journal of Medicine.*

94-118 Estimating Mammography Utilization by Elderly Medicare Women for Whom the Health Care Financing Administration Does Not Receive Administrative Claims

Project No.:	500-92-0020DO11
Period:	September 1994–April 1996
Funding:	$ 110,074
Award:	Delivery Order in Master Contract
Principal Investigator:	Janet B. Mitchell, Ph.D.
Awardee:	Health Economics Research, Inc. (See page 206)
HCFA Project Officer:	Anne E. Trontell, M.D. Division of Health Information and Outcomes

Description: This delivery order will provide basic information relevant to the use of the Health Care Financing Administration's (HFCA) administrative claims data for monitoring the use of preventive services in HCFA's Consumer Information Initiative. Information developed under this delivery order will assist in understanding potential deficiencies in HCFA's administrative claims data for measuring mammography utilization, since self-reported utilization of mammography is typically higher than rates calculated from Part B claims data. The project will identify potential reasons for discrepancies between survey and claims data and will attempt to quantify the magnitude of discrepancies. Preliminary analyses suggest a role for person-level comparison of the survey reports and claims experience of Medicare Current Beneficiary Survey (MCBS) respondents.

HCFA intends to monitor the use of mammography by its elderly female beneficiaries and so wishes to understand the strengths and weaknesses of administrative data for this monitoring function. Understanding the differences between claims-based rates and those based on survey self-reports will facilitate joint mammography efforts with the Public Health Service (PHS); these include the mammography screening objectives of the PHS Healthy People 2000 and the health services research goals of the Secretary's National Breast Cancer Action Plan.

Status: Preliminary estimates of data differences have been developed. Refinement of these estimates is ongoing, and analyses of mammography utilization using the MCBS are being developed.

92-069 Evaluation of the Demonstration for Improving Access to Care for Pregnant Substance Abusers

Project No.:	500-92-0049
Period:	September 1992–September 1997
Funding:	$ 2,131,844
Award:	Contract
Principal Investigator:	Embry Howell, Ph.D.
Awardee:	Mathematica Policy Research, Inc. P.O. Box 2393 Princeton, NJ 08543-2393
HCFA Project Officer:	Suzanne Rotwein, Ph.D. Division of Health Information and Outcomes

Description: The awardee is conducting an evaluation of the demonstration to improve access to Medicaid care for pregnant substance abusers. The demonstration is being implemented in Maryland, Massachusetts, New York, South Carolina, and Washington. The purposes of these projects are to improve outreach and assessment; expand, integrate, and coordinate program services; and improve client case management. The objective of the evaluation is to assess the effectiveness of interventions that are included in the demonstration projects. The evaluator will be responsible for reporting on the implementation process of the demonstration and on the demonstration's effect on access to prenatal care, substance abuse treatment services, and other relevant services. The evaluation will assess the effects of services on the health of drug-addicted pregnant women, any prevention or reduction of short-term impairments to their infants, and the impact on birth outcomes. The evaluation also will compare the cost of substance abuse treatment in residential facilities versus ambulatory care facilities.

Status: The awardee has prepared a final evaluation design and data collection instrument and has implemented data collection. Site visits are being used to assess the status of the implementation of the demonstration, negotiate with providers for implementing the survey, and collect data for the process analysis.

95-015 Evaluation of the Iowa Implementation of Ambulatory Patient Groups (APGs)

Project No.:	500-92-0047
Period:	April 1995–April 1997
Award:	Contract
Funding:	$ 322,218
Principal Investigator:	George Wright
Awardee:	Mathematica Policy Research, Inc. 600 Maryland Avenue, SW. Suite 550 Washington, DC 20024-2512
HCFA Project Officer:	Joseph M. Cramer Division of Payment Systems

Description: Under this contract, Mathematica will design and implement an evaluation of the Iowa Medicaid Program outpatient prospective payment system. Iowa will use the APG system developed by 3M-Health Information Systems. The focus of the task will be to perform a preliminary evaluation of the APG system using data collected from the facilities and the State. In addition, Mathematica will describe the implementation of APGs in two Blue Cross/ Blue Shield plans in Ohio and California. The evaluation activities to be conducted by the contractor will consist of a case study of Iowa's development and implementation of the APG system followed by an analysis of the project's reimbursement methodology. The purpose of the analysis is to assess the application of the APG system for potential implementation by Medicare on a national basis.

Status: The contractor is working on the evaluation design report.

91-015 Evaluation of the Medicaid Extension Demonstrations (Formerly, Evaluation of the Medicaid Expansion Demonstrations)

Project No.:	500-87-0030TO10
Period:	June 1991–March 1995
Funding:	$ 927,357
Award:	Technical Support: Evaluation of Demonstrations
Principal Investigator:	David Kidder, Ph.D.
Awardee:	Abt Associates, Inc. 55 Wheeler Street Cambridge, MA 02138-1168
HCFA Project Officer:	Paul J. Boben, Ph.D. Office of State Health Reform Demonstrations
Mandate:	Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239)

Description: For this project, the awardee will design and conduct the evaluation of three demonstrations mandated under section 6407 of the Omnibus Budget Reconciliation Act of 1989. The awardee will evaluate alternative models for extending health insurance coverage to children under 20 years of age who lack insurance. The States conducting the demonstrations are Florida, Maine, and Michigan. Each State will use a different strategy for providing the new coverage. Florida will test the effectiveness of marketing a school-based affordable insurance package that delivers services through a managed care network. Maine will conduct a statewide program that subsidizes comparable private employer-based group coverage, where such insurance is shown to be cost-effective. Michigan will test the effectiveness of a public-private partnership between the State and Michigan Blue Cross and Blue Shield, using donated funds to subsidize a mainstream outpatient insurance package. The evaluation will determine the effect of these demonstrations on various outcome and process measures of access to care, private insurance coverage, and cost of care. Methodology to be used will take into account the distinctiveness of the three demonstrations, while incorporating a strategy that will allow for comparisons between programs in terms of performance in penetrating the eligible population. Case studies will be coupled with the analysis of program data to describe the structure and processes of the demonstrations. In addition, primary data will be collected through surveys of both program participants and controls. Separate analyses of program costs and program effectiveness will be included.

Status: The Health Care Financing Administration has received from Abt Associates, Inc. the most recent draft interim report, dated September 1, 1994. The report contains comparisons between the three demonstration sites of enrollment and utilization, based on enrollment, claims, and encounter data obtained from the sites. Results from the demonstration sites also were evaluated, based on comparable measures derived from the National Health Interview Survey. Preliminary statistical analysis of the effect of the demonstrations on access, use, out-of-pocket expenditures, and satisfaction was included, as were case study reports on all three demonstration sites (reflecting the outcomes of recent site visits to Michigan and Florida). The second wave of telephone interviews is the next major task to be accomplished.

92-064 Evaluation of the Medicaid Uninsured Demonstrations

Project No.:	500-92-0062
Period:	September 1992–September 1996
Funding:	$ 1,313,458
Award:	Contract
Principal Investigator:	Margo L. Rosenbach, Ph.D.

Awardee:	Health Economics Research, Inc. 300 Fifth Avenue, 6th Floor Waltham, MA 02154
HCFA Project Officer:	James P. Hadley Office of State Health Reform Demonstrations
Mandate:	Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: The purpose of this contract is to design and conduct the evaluation of three demonstration projects being conducted in Maine, South Carolina, and Washington State. These demonstrations, implemented in response to a congressional mandate under section 4745 of the Omnibus Budget Reconciliation Act of 1990, are intended to test the effect of allowing States to extend Medicaid coverage to low-income families. Evaluation contract deliverables will include a series of annual reports, an interim and a final Report to Congress, and a final evaluation report. The evaluator will examine within and between site processes and outcomes, including the following:

- Ability of the programs to enroll significant numbers of eligible persons.
- Conditions under which eligible persons and their families are willing to participate in such programs, given their scarce financial resources.
- Ability of the programs to induce adequate numbers of providers to ensure the availability of necessary services at appropriate levels of utilization.
- Willingness of employers to participate in the programs and the conditions under which they do or do not choose to do so.
- Program's effect on service utilization and health outcomes of participants.
- Cost-effectiveness of such programs for the various public and private interests.
- Extent to which the demonstration's interventions could be applied nationally to assist in achieving program goals.

Status: The evaluator conducted an initial series of site visits during 1993. Their first annual report used data collected during these site visits and data from State-administered baseline surveys to describe the implementation phase and early operational phase of the demonstrations. A second series of site visits was performed during 1995. A second annual report based on these visits and designed to examine process issues for the first operational years of the demonstrations is due to be completed by the end of 1995. The site visits, along with surveys of the covered populations (which will provide information on participants' health status, reasons for enrolling in the demonstration, and satisfaction with the programs) and use and cost data from the demonstration sites will provide the basis for the final report, due September 1996.

95-058 Evaluation of Rural Health Clinics

Project No.:	500-92-0047DO03
Period:	September 1995–March 1997
Funding:	$ 316,051
Award:	Delivery Order in Master Contract
Principal Investigator:	Valerie Cheh, Ph.D.
Awardee:	Mathematica Policy Research, Inc. (See page 205)
HCFA Project Officer:	Siddhartha Mazumdar, Ph.D. Division of Delivery Systems and Financing

Description: The Rural Health Clinic Services Act of 1977 (Public Law 95-210) authorized a new type of provider for certification and licensure. A rural health clinic (RHC) must be located in a rural health professional shortage area, medically underserved area, or Governor-designated shortage area, and it must make use of mid-level practitioners. The legislation provides for cost-based reimbursement for the clinics for Medicare and Medicaid. After a slow start in certifying clinics in the first years of the program, there has been rapid growth in the numbers of these clinics in the past few years. According to a count by the Health Care Financing Administration, there were 2,057 RHCs listed nationwide in January 1995, compared to 1,157 certified clinics in August 1993.

The purpose of this contract is an evaluation of this program, which will focus on several broad issue areas that have implications for rural health policy at the Federal and State levels. These overall issue areas areas follows: (1) What are the reasons for the growth in the numbers of the RHC? (2) What has been the impact on access to health care for rural populations as a result of the growth in these clinics, especially the Medicare, Medicaid, and otherwise underserved populations? (3) What have been the costs to the Federal Government and the States for the program? Other broad questions pertinent to the entire spectrum of rural health policy will also be addressed, such as whether these clinics are increasing the supply of physicians in rural areas, what implications the growth in clinics has for Federal policy for rural hospitals and other providers, and whether these clinics should be protected in the development of State managed care plans.

Status: This project is in the early development stage.

93-076 Examination of the Medicaid Expansions for Children

Project No.:	500-93-0042
Period:	September 1993–March 1996
Funding:	$ 648,416
Award:	Contract
Principal Investigator:	Genevieve Kenney, Ph.D.

Awardee:	The Urban Institute 2100 M Street, NW. Washington, DC 20037
HCFA Project Officer:	Judith A. Sangl, Sc.D. Division of Health Information and Outcomes

Description: This project will focus on Medicaid eligibility expansions for children. These expansions were legislated as part of the Omnibus Budget Reconciliation Acts of 1989 and 1990. Analyses on the impact of the expansions include examination of enrollment and expenditure trends from 1988 to 1992; assessment of the extent to which the expansions penetrated the target population; and multivariate analysis to examine the impact of State policies and the eligibility group on enrollment, expenditures, and utilization of services. Steps to examine access to care and utilization of services include the development of a theoretical model, an analysis plan, and items that could be incorporated into an established national survey.

Status: The following tasks have been completed or begun:

- A review of proposed health reform bills and how they affect children.
- A report entitled "Toward Evaluating the Effects of the Medicaid Eligibility Expansions on Low-Income Children's Access to Care and Service Use." This report outlines a theoretical model of children's health care use and used the theoretical model to identify data that would be required to evaluate the effects of the Medicaid policy expanding eligibility to low-income children on their access to care and service use.
- Enrollment and expenditure tables to examine trends between 1987 and 1992 and to compare enrollment groups for the four Tape-to-Tape States of California, Georgia, Michigan, and Tennessee. These allow an assessment of enrollment and expenditure patterns as they vary over time and across groups of enrollees.
- Analytic files based on the Urban Institute's TRIM2 microsimulation model to assess changes in insurance coverage among children.
- Data file construction and variable specification to estimate state-level enrollment models for children.

94-105 **Extension of Medicaid Benefits for Post-Partum Women**

Project No.:	11-W-00007/4
Period:	January 1994–December 1998
Funding:	Waiver only
Award:	Waiver-only Project
Principal Investigator:	Robert Ehrlich
Awardee:	South Carolina State Health and Human Services Finance Commission P.O. Box 8206 Columbia, SC 29202-8206
HCFA Project Officer:	Suzanne Rotwein, Ph.D. Division of Health Information and Outcomes

Description: South Carolina's Extension of Medicaid Benefits for Post-Partum Women seeks to increase the amount of time between pregnancies by extending and expanding family planning services to post-partum women. Under current law, if a woman is eligible for Medicaid only because of her pregnancy (i.e., her income is otherwise too high), Medicaid family planning benefits continue for 60 days after giving birth. In this project, South Carolina is extending coverage for an additional 22 months. The project is expected to serve approximately 20,000 women a year. Women whose family income is at or below 185 percent of the Federal poverty level at the time of giving birth are eligible for a defined set of family planning services during the additional 22-month period, without regard to subsequent changes in income level. South Carolina will evaluate the project by using State vital records and Medicaid Management Information Systems data to do trend analyses within comparable populations to measure the effect of the demonstration. Measures will include pregnancies averted or postponed and improvement in birth outcomes (e.g., reductions in premature births, low birthweight, neonatal intensive care unit cases).

Status: The project became operational on July 1, 1994.

93-070 **Federally Qualified Health Centers**

Project No.:	500-92-0037/01 (for Medicaid Demonstration and Evaluation Support Projects: Master Contract)
Period:	September 1993–January 1996
Funding:	$ 283,465
Award:	Delivery Order in Master Contract
Principal Investigator:	Judith Wooldridge
Awardee:	Mathematica Policy Research, Inc. (See page 201)
Project Officer:	Alisa Adamo Office of State Health Reform Demonstrations

Description: The Office of Research and Demonstrations awarded a contract in September 1993 to assess how the provision of health services through Federally Qualified Health Centers (FQHCs) has influenced access to, use of, and cost of health services to Medicare and Medicaid beneficiaries. The first phase of the contract determined the feasibility of doing a valid quantitative study. FQHC service-use data are not readily available in a central data

base. Many of the research questions need detailed service-specific data in order to be answered. By the end of the first phase, the contractors had finalized the study design and were ready to begin conducting the quantitative study (the second phase). The basic study design focuses on the analyses of Medicaid claims data in two States. It is a pre-post design using data from 1988 through 1992. Contrary to what was originally envisioned, the impact of FQHCs on the Medicare program will not be assessed in this study.

The objective of the study is to better understand the characteristics of Medicaid FQHC users, their service use, and expenditure patterns relative to non-FQHC users, and the impact over time of the FQHC program on users' service use and expenditures, FQHCs and the Medicaid program.

Preliminary assessment of data from Michigan indicates that between 1989 (before the implementation of FQHC policies) and 1992 (after full implementation) the number of Medicaid users in FQHCs roughly doubled, the level of service use in FQHCs (i.e., services per user) grew slightly, and Medicaid payments to FQHCs increased significantly because of the changes in FQHC payment policies.

Status: The final report is expected in January 1996 and will contain additional analysis of data from Michigan and from California.

94-068 **Florida Welfare Reform: Family Transition Program**

Project No.:	11-W-00011/4
Period:	January 1994–December 2001
Funding:	Waiver only
Award:	Waiver-only Project
Principal Investigator:	H. James Towey
Awardee:	Florida Department of Health and Rehabilitative Services 1317 Winewood Boulevard Tallahassee, FL 32399-0700
Project Officer:	Alisa Adamo Office of State Health Reform Demonstrations

Description: This demonstration has waivers from the Health Care Financing Administration and the Administration for Children and Families to do the following:

- Allow two-parent families to have the same eligibility criteria as single-parent families and disregard the income of stepparents for the first 6 months of receipt of Aid to Families with Dependent Children (AFDC).
- Impose financial sanctions on families if children do not attend school regularly or are not immunized.
- Limit the receipt of AFDC benefits to 24 months in any 60-month period.
- Require recipients whose youngest child is over 6 months of age to participate in the Jobs Opportunity and Basic Skills program.
- Increase disregard of earnings and asset limits.
- Increase transitional child care benefits.
- Eliminate quarterly income reporting during the Medicaid transition benefit period, but require recipients to report income increases.

Medicaid waivers were required in order to eliminate the need for income reporting during the transition benefit period.

Status: The program was implemented in March 1994 in two counties, and the demonstration area was recently expanded to include a total of six counties. The provision has not been implemented.

94-119 **Health Risk Appraisal for Older Persons**

Project No.:	17-C-90300/9
Period:	September 1994–September 1996
Funding:	$ 250,000
Award:	Cooperative Agreement
Principal Investigator:	Lester Breslow, M.D.
Awardee:	University of California at Los Angeles School of Public Health 1100 Glendon Avenue, Suite 711 Los Angeles, CA 90024-3511
HCFA Project Officer:	Joan L. Warren, Ph.D. Division of Health Information and Outcomes

Description: The project will expand on existing work to develop a method to reduce behavioral risk factors among elderly people, which may reduce the frequency and extent of functional impairment. In previous work, the awardee developed a self-administered health risk appraisal that identified specific behavioral risk factors. This project will refine the existing survey instrument for use with elderly people. The final product will include a questionnaire, software developed for the questionnaire, feedback on algorithms and related software needed to produce personalized reports for participants and their physicians, documentation for the system, and instructions that can be given to participants and their physicians on how to use the system and to interpret the results.

Status: The cooperative agreement was awarded on September 28, 1994. During the first year, the questionnaire and algorithms for the questionnaire were finalized. In the second and final year of the project, the awardee is arranging to field test the questionnaire in two managed care organizations and a senior center.

94-039 Hospital Obstetrical Care: A Comparison of Quality Indicators in Medicaid Fee-for-Service and Medicaid-Managed Care Groups

Project No.:	18-P-90429/5
Period:	September 1994–September 1996
Funding:	$ 257,681
Award:	Grant
Principal Investigator:	Denise M. Oleske, Ph.D.
Awardee:	Rush University 1653 West Congress Parkway Chicago, IL 60612-3833
HCFA Project Officer:	Judith A. Sangl, Sc.D. Division of Health Information and Outcomes

Description: The objectives of this study are to describe and ascertain differences in the prevalence of clinical quality indicators in Medicaid fee-for-service, Medicaid-managed care, and private managed-care groups for maternal and child hospital obstetrical care. Data from California and Florida will be used. Data sources for this project include birth and fetal death certificates, hospital discharge abstracts, Medicaid eligibility files, and the American Hospital Association Annual Survey.

Status: The following tasks have been begun or completed:

- Obtained, for California, all needed computer tapes on Medicaid recipient characteristics, Medicaid fee-for-service claims, hospital discharge abstracts, and birth and death fetal certificates. Medicaid eligibility and claims files and birth and fetal death certificates have been obtained for Florida.
- Selected a random sample of women from California and Florida birth certificates and requested medical record consent forms from them.
- Developed and sent surveys to hospital obstetrical departments and managed care plans.
- Created analytic files and linked several files.

93-028 Hypermedia-Based Health Insurance Counselor Performance Support System

Project No.:	97-P-08042/5-01 (Phase I) 97-P-08042/5-02 (Phase II)
Period:	February 1993–January 1994 (Phase I) February 1994–January 1995 (Phase II)
Funding:	$ 34,999 (Phase I) $ 118,719 (Phase II)
Award:	Grant
Principal Investigator:	Sara Derenge
Awardee:	Technovation Training, Inc. Executive Court Professional Centers 3454 Oak Alley Court, Suite 209 Toledo, OH 43606-1317
HCFA Project Officer:	Leslie A. Mangels Financial, Administrative, and Procurement Staff
Mandate:	Small Business Innovation Development Act of 1982 (Public Law 97-219; amended by the Small Business Innovation Research Program, Extension, Public Law 99-443)

Description: The purpose of this project was to facilitate consistency among statewide efforts in terms of the State's capability to train and support the performance of volunteers and others who will provide this counseling.

Status: The project has been completed. Because the Small Business Innovation Research program sponsors the development of commercially viable products, it carefully protects the developer's intellectual property. Any detailed information on this project and the product must be obtained from the awardee.

92-016 Identifying Barriers to Elderly Participation in the Qualified Medicare Beneficiary Program

Project No.:	17-C-90094/3
Period:	February 1992–December 1994
Funding:	$ 334,040
Award:	Cooperative Agreement
Principal Investigator:	Peter J. Neumann, Ph.D.
Awardee:	The People-to-People Health Foundation, Inc. Center for Health Affairs 7500 Old Georgetown Road, Suite 600 Bethesda, MD 20814-6133
HCFA Project Officer:	Feather Ann Davis, Ph.D. Division of Aging and Disability

Description: This study of the Qualified Medicare Beneficiary (QMB) program introduced by the Medicare Catastrophic Coverage Act of 1988 uses data from the Medicare Current Beneficiary Survey and the 1990 Population Census to estimate the magnitude of enrollment and nonenrollment. The project produces national estimates of the size and characteristics of the elderly populations enrolled and not enrolled in the QMB program; identifies the most significant barriers to program participation and the most frequent sources of information that would facilitate participation; and develops a methodology for identifying local areas where nonenrollees are most likely to reside and where outreach programs tailored to the needs and preferences of different subpopulations of poor elderly might be effective.

Status: The three-volume final report has been received:

- Neumann, P., Bernardin, M., Boyer, E., and Evans, W.: "Identifying Barriers to Elderly Participation in the Qualified Medicare Beneficiary Program." Bethesda, Maryland, August 23, 1994.
- Neumann, P., Bernardin, M., Boyer, E., and Evans, W.: "Identifying Barriers to Elderly Participation in the Qualified Medicare Beneficiary Program." Bethesda, Maryland, July 12, 1995.
- Parente, S.T., Evans, W.N., and Bayer, E.J.: "The Impact of QMB Enrollment on Medicare Costs and Service Utilization." Bethesda, Maryland, July 12, 1995.
- "Appendix C: The Mapping Project." Bethesda, Maryland, August 30, 1994.

Findings: The study found that, like other means-tested government assistance programs, identification and enrollment of eligible individuals in the QMB program was problematic. By 1992, an estimated 41.3 percent of the eligible beneficiaries were enrolled as Medicare buy-ins, about 1.9 million persons out of 4.7 million eligible. A third of those buy-ins are designated as QMBs, therefore having all of their cost-sharing paid for by Medicaid, while the other two-thirds have their Part B premiums paid. State coding practices may not accurately reflect the number of QMBs. Those beneficiaries who are enrolled as QMBs tend to be those most in need of the program. Nonparticipating eligibles are not enrolling because they do not believe they need the program, they do not believe they qualify, or because they are not aware of the program. The study of the use of services among QMB-eligible beneficiaries shows that those enrolled in QMB have significantly higher probability (12 percentage points) and intensity of Part B Medicare use than those not enrolled. The health status of QMBs is poorer than those of eligible nonenrollees. On average, QMB enrollees incur $1,900 more per year on health services covered by Medicare Part B and $1,300 more per year on Medicare Part A services than do eligible nonenrollees. The probability of having any Medicare Part A expenses is eight percentage points higher among QMBs than among eligible nonenrollees. However, there is no difference between these two groups in Part A expenditures for those who have any Part A charges. Econometric analyses were unable to determine whether or not the correlation between enrollment and use is a function of adverse selection or induced demand.

94-109 Identifying Drug Therapy Inappropriateness: Determining the Validity of Drug Use Review Screening Criteria

Project No.:	18-C-90302/3
Period:	September 1994–August 1996
Funding:	$ 209,428
Award:	Cooperative Agreement
Principal Investigator:	Ilene Zuckerman, Pharm.D.
Awardee:	University of Maryland at Baltimore Center on Drugs and Public Policy School of Pharmacy 511 West Lombard Street Baltimore, MD 21201
HCFA Project Officer:	Kathleen Gondek, Ph.D. Division of Payment Systems

Description: The purpose of this study is to determine if outpatient drug use review (DUR) screening identifies clinically significant cases of inappropriate drug prescribing in the Medicaid program. The objectives of the study are as follows:

- Quantify the agreement between a DUR screening of Maryland Medicaid claims data with the medical record.
- Test the hypothesis that cases of appropriate antihypertensive drug therapy are associated with lower mean blood pressures.
- Outline a method to establish standards of acceptable variation from the drug therapy inappropriateness criteria for drugs used to treat hypertension.
- Produce a manual for Medicaid DUR programs on assembling a minimal data set to permit an ongoing assessment of the usefulness of DUR screening of Medicaid claims data.

Status: Replication of the content validity of the screening criteria used to indicate drug therapy inappropriateness in the treatment of hypertension is complete. Practitioners have been trained to review medical records data and assess the drug therapy appropriateness. Completion of this project is anticipated in Fall 1996.

93-042 **Illinois Welfare Reform: Homeless Families Stabilization** (Formerly, Illinois Homeless Families Stabilization)

Project No.:	11-P-90242/5
Period:	May 1993–June 1998
Award:	Waiver only
Principal Investigator:	Robert Wright
Awardee:	Illinois Department of Public Aid 100 South Grand Avenue East Springfield, IL 62762-0001
Project Officer:	Alisa Adamo Office of State Health Reform Demonstrations

Description: This demonstration has waivers from the Health Care Financing Administration and the Administration for Children and Families. The Illinois demonstration provides one-stop shopping for services for homeless families who are eligible for Aid to Families with Dependent Children; increases the asset limit and the disregard of earnings in the first 2 years of employment; and provides a 24-month Medicaid transition benefit with no income limit for those families who work their way off welfare.

Status: Demonstration waivers were implemented on July 1, 1994. In general, the demonstration has had some difficulty in obtaining participants for the program. In order to test the hypotheses properly, an enrollment of 600 families was required. However, only 300 families have enrolled in the demonstration. The State is increasing its efforts to recruit more participants.

92-020 **Impact of Complicating Diseases on End Stage Renal Disease Outcomes and Costs**

Project No.:	17-C-90082/3
Period:	February 1992–December 1994
Funding:	$ 321,044
Award:	Cooperative Agreement
Principal Investigator:	Neil Powe, M.D.
Awardee:	The Johns Hopkins University School of Medicine 720 Rutland Avenue Baltimore, MD 21205
HCFA Project Officer:	Lawrence E. Kucken Division of Health Information and Outcomes
Mandate:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509)

Description: The purpose of this project is to examine patient and provider characteristics associated with complicating diseases within the end stage renal disease (ESRD) population and the effects of these disease patterns on patient outcomes, utilization, and costs. The study design involves longitudinal analyses of ESRD patients to determine risk factors associated with the onset of complicating illness and outcomes such as hospitalization and mortality. The study period covers the years 1984 through 1990 and will draw upon data from the ESRD Program Management and Medical Information System and other Medicare statistical files.

Status: The final report is currently under develoment.

92-010 **Impact of Medicaid Eligibility Expansions and Innovative Programs for Maternal Health Care**

Project No.:	18-C-90113/9
Period:	February 1992–December 1994
Funding:	$ 301,000
Award:	Cooperative Agreement
Principal Investigator:	Stephen H. Long, Ph.D.
Awardee:	The RAND Corporation 1700 Main Street P.O. Box 2138 Santa Monica, CA 90407-2138
HCFA Project Officer:	Herbert A. Silverman, Ph.D. Division of Payment Systems

Description: The focus of this project is to assess the impact of the Medicaid eligibility expansions on the financing and use of health care services by all women and newborns in Florida, regardless of their source of insurance, if any. To assess the aggregate impacts of the changes, the analytic approach to be taken is to estimate the flow of funds for perinatal care before and after the Medicaid expansion.

Status: Because of funds received from the March of Dimes, the scope of the study was expanded to include an analysis of pregnancy outcomes resulting from lowered financial barriers to prenatal care. The investigators have submitted a first draft of the report. The preliminary findings are the following:

- The number of prenatal visits paid by the Florida Medicaid program increased from 403,600 in 1988 to 729,700 in 1991, an increase of almost 81 percent. In 1988, Medicaid paid 20.2 percent of all prenatal visits; by 1991, the Medicaid share increased to 32.8 percent.
- Among mothers eligible for Medicaid coverage by reason of the expansions, the percent who received no prenatal care decreased from 1.7 percent in 1988 to 1.3 percent in 1991. During the same interval, among pregnant women with other or no insurance and living in areas with more than 30 percent of the population with an income below

150 percent of the Federal poverty level, the percent receiving no prenatal care increased from 3.9 to 4.0 percent. The investigators conclude from this difference that providing Medicaid benefits to low-income women appears to increase their use of prenatal services relative to what they would be expected to use if uninsured.

- The number of deliveries in which Medicaid was the primary payer increased from 47,500 in 1988 (23.0 percent of all deliveries) to 77,100 in 1991 (36.1 percent of all deliveries).
- Among mothers eligible by reason of the Medicaid expansions, the incidence of low- birthweight deliveries decreased from 71 per 1,000 deliveries in 1988 to 61.1 per 1,000 in 1991. Among mothers with other or no insurance, the incidence of low-birthweight deliveries remained virtually unchanged: 71.9 per 1,000 in 1988 and 71.2 per 1,000 in 1991.
- Despite greater access to care and improved outcomes among mothers eligible by virtue of the Medicaid expansions, they do not reach the levels attained by privately insured women.

92-031 **Impact of the Medicare Fee Schedule on Access to Physician Services**

Project No.:	17-C-90037/1
Period:	March 1992–June 1996
Funding:	$ 768,498
Award:	Cooperative Agreement
Principal Investigator:	Janet B. Mitchell, Ph.D.
Awardee:	Center for Health Economics Research, Inc. 300 Fifth Avenue, 6th Floor Waltham, MA 02154
HCFA Project Officer:	Renee Mentnech Division of Health Information and Outcomes

Description: The purpose of this project is to evaluate the impact of the Medicare Fee Schedule (MFS) on access to care. A sample of beneficiaries will be selected for study from six strata reflecting the size of the payment change under the MFS. Access for vulnerable segments of the population will be measured both in terms of use and outcomes, as well as financial liability. National trend data also will be developed. In addition, changes in regular source of care and difficulties obtaining care also will be assessed using the Medicare Current Beneficiary Survey (MCBS).

Status: A nationally representative sample has been drawn, and Medicare use data have been assembled for the sample. Measures of outcomes (such as admissions for ambulatory care sensitive conditions) and use (such as use of preventive services) have been developed for vulnerable groups and for geographic areas by expected MFS payment change. The 1991 outcome measurements were compared with the 1992 and 1993 data to identify any changes in the first and second years of the MFS. The 1991 use measurements were compared with to the 1992 data to identify any changes in the first year of the MFS. Access measures from Rounds 1, 4, and 7 of the MCBS (1991, 1992, and 1993 data, respectively) have been developed. Results from this project have been incorporated into the 1993, 1994 and 1995 Reports to Congress on access. Substantial differences between vulnerable population subgroups were identified. Preliminary results suggest, however, that access neither worsened nor improved during the first and second years of MFS implementation.

91-034 **Implementing Findings on Volume and Quality**

Project No.:	99-C-98526/1
Period:	August 1991–December 1992
Funding:	$ 115,181
Award:	Cooperative Agreement
Principal Investigator:	Joel M. Cohen
Awardee:	Brandeis University Heller Graduate School Institute for Health Policy 415 South Street P.O. Box 9110 Waltham, MA 02254-9110
HCFA Project Officer:	Gerald F. Riley Division of Health Information and Outcomes

Description: The purpose of this study is to provide a descriptive analysis of the distribution, by hospital, of Medicare cases for selected procedures and services. Researchers will provide data on the feasibility of concentrating certain procedures among a limited number of hospitals. Interest in this regionalization of certain procedures follows from previous studies indicating that better patient outcomes are associated with hospitals that perform high volumes of the procedures. National statistics will provide information on the number of hospitals doing the procedures and the range of volumes across these hospitals. Breakdowns by hospital characteristics will indicate whether there seems to be a low-volume problem for any particular type of hospital. Market-level statistics on the distribution of procedures across hospitals will provide information on the extent to which regionalization may be feasible. Because any regionalization involves some reduction in access, it is important to document the magnitude of this effect. The distribution of surgeon volumes also will be studied for the State of Alabama. Linking surgeon and hospital volume data will permit the examination of the relationship between surgeon and hospital volumes. The primary source of data will be the Medicare provider analysis and review file records for hospital stays occurring in 1987 and 1990. These data will

be merged with metropolitan statistical area identifiers, the area resource file, and an American Hospital Association survey. Data from all Part B physician claims for the State of Alabama will be used for the analysis of surgeon volumes. The study's investigators also will identify alternative strategies for promoting regionalization.

Status: The final report, "Implementing Findings on Volume and Quality: Final Report," is available through the National Technical Information Service, accession no. PB95-173183. The analysis of surgeon volumes could not be conducted because of data problems.

95-048 Maryland Welfare Reform: Family Investment Program

Project No.:	11-W-00066/3
Period:	October 1995–June 1998
Funding:	Waiver only
Award:	Waiver-only Project
Principal Investigator:	Alvin C. Collins
Awardee:	Maryland Department of Human Resources 311 West Saratoga Street Baltimore, MD 21201-3521
HCFA Project Officer:	Joan Peterson Office of State Health Reform Demonstrations

Description: This demonstration will consist of two components: one to be implemented statewide and the other, a pilot, to be implemented in two counties and in two district offices in Baltimore City. Statewide, the project will require unmarried teenage parents to reside with a guardian; eliminate increased Aid to Families with Dependent Children (AFDC) benefits for additional children conceived while the mother is receiving AFDC, but provide third-party payment or voucher/vendor payment for the difference; and issue AFDC benefits 14 days after the application date. In the pilot sites, the demonstration will be testing a number of provisions designed to encourage work and the transition to self-sufficiency. It will provide one-time payment in lieu of AFDC benefits for families facing a short-term financial crisis; disregard stepparent income if it is below 100 percent of the Federal poverty level (FPL); reduce the grant by 50 percent of the need standard if income is between 100 and 150 percent of the FPL; base the grant for families with earnings at 85 percent of the difference between the need standard and earnings; eliminate Jobs Opportunity and Basic Skills training program exemptions for having a child under age 3 and for having a medical disability of more than 12 months, unless recipient applies for Supplemental Security Income; after 3 months, require able-bodied recipients to meet a work requirement that may consist of full-time unsubsidized employment, 30 hours of subsidized employment, or a total of at least 20 hours of community service and employment; and several other AFDC provisions. Transitional Medicaid will be extended from 12 to 24 months. For months 13 through 24, this benefit will not be made available where the individual has access to employer-based health insurance.

Status: This project is in the early implementation stage.

95-069 Massachusetts Welfare Reform, 1995

Project No.:	11-W-00065/1
Period:	November 1995–November 2005
Funding	Waiver only
Award:	Waiver-Only Project
Principal Investigator:	Gerald Whitburn
Awardee:	Executive Office of Health and Social Services One Ashburton Place Room 1109 Boston, MA 02108
HCFA Project Officer:	Alisa Adamo Office of State Health Care Reform Demonstrations

Description: The major components of this demonstration are a 2-year time limit on Aid to Families with Dependent Children (AFDC) within every 60 months, with extensions in certain cases, and a work requirement for those on AFDC for more than 60 days. Certain recipients are exempt from the time limit and the work requirement (e.g., the disabled, pregnant women). Recipients who are not exempt will be asked to sign an Employment Development Plan. The plan will address such requirements as school attendance for children and minor parents, immunizations for children, and employment-related requirements for adults. Refusal to sign the plan will result in the case head being sanctioned.

One component in the demonstration is the Full Employment Program, under which AFDC and cashed-out food stamp benefits will be used to provide a wage subsidy. Under this provision, some individuals who are not able to find unsubsidized positions will be placed in subsidized private-sector jobs. A benefit of the Full Employment Program will be an Individual Assets Account, into which the employed pays $1 for each participant hour worked. Upon leaving the Full Employment Program for an unsubsidized job of at least 30 hours per week, or because she/he is no longer employed, or after 12 months of participation in the Full Employment Program, whichever is sooner, the participant may claim the Individual Assets Account. If the money is withdrawn before leaving AFDC, it is a countable resource. However, the account is established as a work incentive and will provide a small sum of money to help in the transition from welfare to independence.

Additional incentives are being provided to encourage people to work. These include income disregards and transitional Medicaid. Medicaid waivers were required in order to provide 12 months transitional Medicaid to families without regard to income.

Status: The program is expected to begin on November 1, 1995.

91-084 Medicaid Extension of Eligibility to Certain Low-Income Families Not Otherwise Qualified to Receive Medicaid Benefits: Extending Medical Coverage to Certain Low-Income Families

Project No.:	11-C-99657/4
Period:	September 1991–August 1996
Funding:	$ 720,774
Award:	Cooperative Agreement
Principal Investigator:	Rochelle Salsman
Awardee:	State of Washington Department of Social and Health Studies 617 Eighth Avenue, SE. Olympia, WA 98504-5510
HCFA Project Officer:	James P. Hadley Office of State Health Reform Demonstrations
Mandate:	Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: Section 4745 of the Omnibus Budget Reconciliation Act of 1990 mandates a 3-year demonstration project to test the effect of eliminating the categorical eligibility requirement and raising the financial eligibility limits to 150 percent of the Federal poverty level (FPL) on low-income individuals' access to and cost of health care. The Washington project, Health Access Spokane (HAS), is a collaborative effort between two State agencies, the Department of Social Services' Medical Assistance Administration, and the Washington Basic Health Plan (BHP). The program covers those who are under 65 years of age, are not eligible for Medicaid, and have incomes below 200 percent of the FPL. In addition to providing coverage to the uninsured, this project tests the ability of the State to provide "seamless" coverage for individuals and families as they move from BHP to demonstration or to Medicaid status. During these transitions, coverage will be maintained and providers will remain the same, although there are differences in benefits available, depending on the program for which the individual is eligible. Individuals living in Spokane eligible to enroll in HAS are the following:

- Current BHP members with family incomes below 150 percent of the FPL.
- Current BHP members who are not enrolled in BHP but who are currently uninsured and have incomes below 150 percent of the FPL.
- Individuals who no longer qualify for Medicaid, but whose family income is below 150 percent of the FPL.

Services are delivered through a health maintenance organization (HMO) and a preferred provider organization (PPO). Enrollees are given a choice of plans. The organizations are paid a negotiated capitation rate, based on past experience with BHP enrollees and the additional benefits that will be offered in the demonstration HMO and PPO. The enrollment goal for the project is 2,950 members. Of this total, 1,200 are conversions from BHP.

Status: HAS began enrollment March 1, 1993. Service delivery began April 1, 1993. Although the State was able to quickly enroll the 1,200 individuals that were "rolled over" from the BHP component, the State has been less successful in enrolling individuals from the two primary populations of interest, and, as of September 1995, only 250 individuals from the group of people losing Medicaid coverage because of increases in income and 350 previously uninsured individuals had been enrolled. Although the demonstration began some preliminary work on the employer component, it dropped this component during Summer 1993 to focus on the enrollment of the previously uninsured. The project will continue providing coverage to enrollees through March 31,1996.

91-077 Medicaid Extension of Eligibility to Certain Low-Income Families Not Otherwise Qualified to Receive Medicaid Benefits: Managed Care Demonstration Project for Low-Income Adults

Project No.:	11-C-99656/1
Period:	September 1991–September 1995
Funding:	$ 211,879
Award:	Cooperative Agreement
Principal Investigator:	Deborah Curtis
Awardee:	Maine Department of Human Services Bureau of Medical Services State House Station No. 11 Augusta, ME 04333
HCFA Project Officer:	Rose M. Hatten Office of State Health Care Reform Demonstrations
Mandate:	Omnibus Budget Reconciliation Act of 1990 (Pulic Law 101-508)

Description: Section 4745 of the Omnibus Budget Reconciliation Act of 1990 requires a 3-year demonstration to test the effect of eliminating the categorical eligibility requirement and raising the financial eligibility limits to

150 percent of the Federal poverty level (FPL) on low-income individuals' access to and cost of health care. Maine is one of three States serving as sites for this demonstration. The 3-year operational period will be preceded by a 9-month planning phase and followed by a 3-month close-out phase. The Maine project is a statewide project that builds on the existing Maine Health Program (MHP), which has been operational since October 1990 and extends Medicaid coverage to adults at or below 95 percent of the FPL. The demonstration differs from the current MHP in two ways: it expands eligibility for adults (20 years of age or over) from 95 percent of the FPL to 100 percent of the FPL and it makes primary care case management mandatory for those enrolled in the demonstration, except for those enrolled through employer-sponsored coverage. Enrollees whose employers offer them coverage are required to accept it if Maine finds it cost-effective to buy in.

Status: Maine passed legislation mandating the privatization of the MHP by April 1, 1995, at which time the demonstration ended.

91-083 Medicaid Extension of Eligibility to Certain Low-Income Families Not Otherwise Qualified to Receive Medicaid Benefits: South Carolina Health Access Plan (SCHAP)

Project No.:	11-C-99653/4
Period:	September 1991August 1996
Funding:	$ 500,000
Award:	Cooperative Agreement
Principal Investigator:	Bruce Bondo
Awardee:	South Carolina State Health and Human Services Finance Commission P.O. Box 8206 Columbia, SC 29202-820
HCFA Project Officer:	James P. Hadley Office of State Health Reform Demonstrations
Mandate:	Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: Section 4745 of the Omnibus Budget Reconciliation Act of 1990 mandates a 3-year demonstration project to test the effect of eliminating the categorical eligibility requirement and raising the financial eligibility limits to 150 percent of the Federal poverty level (FPL) on low-income individuals' access to and cost of health care. In two South Carolina counties (Hoary and Marion), uninsured individuals below 150 percent of the FPL who are employed by small firms that have not offered health insurance coverage to their employees within the past 12 months will be offered coverage for themselves and their families. To be eligible for participation, employers must be located in 1 of the 2 demonstration counties, employ a minimum of 3 and a maximum of 100 employees, and not offer health insurance currently within the past 12 months. Individuals employed are eligible if they have South Carolina residency; have total family incomes under 150 percent of the FPL; are under 65 years of age; and are not currently covered by Medicaid, Medicare, or other health insurance programs. All care is delivered through a primary care gatekeeper system. Physicians in the demonstration area who meet the credential requirement for participation in Medicaid are recruited to participate in the demonstration. Each participating physician is paid a monthly fee of $ per enrollee to manage the care of each assigned patient. Demonstration recipients are able to choose a physician gatekeeper from a list of participating physicians for their health care, as well as an early, periodic screening, diagnosis, and treatment (EPSDT) provider for their children's health care (both could be the same person if the selected physician gatekeeper is also an EPSDT screener). The primary care physician gatekeeper is responsible for managing, coordinating, and controlling the member's/family's use of health care services through the direct provision of comprehensive primary care services (including providing for 24-hour, 7-day-a-week access by telephone), authorizing specialist visits, and granting prior approval of any hospitalizations. Enrollment is projected to be approximately 1,300 participants during each year of the demonstration.

Status: Enrollment began March 1, 1993. Service delivery began April 1, 1993. As of September 1, 1995, enrollment in the demonstration stood at 1,204. Since the demonstration's delivery of services is scheduled to end March 31, 1996, SCHAP stopped accepting new businesses as of July 1, 1995, and stopped enrolling new members from existing businesses October 1, 1995.

90-064 Medicaid Extension of Eligibility to Pregnant Women and Children Demonstration: Florida Medicaid Program and School Enrollment-Based Health Insurance

Project No.:	11-C-99638/4
Period:	September 1990–April 1995
Funding:	$ 274,020
Award:	Cooperative Agreement
Principal Investigator:	Jane Allgood
Awardee:	Florida Agency for Health Care Administration 1317 Winewood Boulevard Building 6, Room 271 Tallahassee, FL 32399-0700
HCFA Project Officer:	Rose M. Hatten Office of State Health Care Reform Demonstrations

Mandate: Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239)

Description: As mandated by section 6407 of Public Law 101-239, this project extended Medicaid to children 6 through 18 years of age who are from families with incomes of less than 185 percent of the Federal poverty level. Low-cost commercial health insurance was marketed through the Florida school system by means of a nonprofit corporation, the Healthy Kids Corporation, established by the State to facilitate the provision of preventive health care services to children and to provide comprehensive coverage to children and their families. The insurance package had both a high (comprehensive) and a low (preventive and primary care only) option plan. The package was based on Medicaid reimbursement rates and provider networks consisting primarily of pediatricians and family practitioners who currently contract with Medicaid. Services were provided by the Florida Health Care Plan, a health maintenance organization under contract with the Healthy Kids Corporation.

Status: The project ended on April 1, 1995. The final report from the State is expected in Spring 1996.

90-066 Medicaid Extension of Eligibility to Previously Ineligible Children Demonstration: Michigan Caring Program for Children (CPC)

Project No.:	11-C-99633/5
Period:	September 1990–August 1995
Funding:	$ 115,000
Award:	Cooperative Agreement
Principal Investigator:	Champa Bhatia
Awardee:	Michigan Department of Social Services 400 South Pine Street Lansing, MI 48909
HCFA Project Officer:	Paul J. Boben, Ph.D. Office of State Health Care Reform Demonstrations

Mandate: Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239)

Description: As mandated by section 6407 of Public Law 101-239, this program will extend Medicaid eligibility to children 6 through 18 years of age who are from families with incomes of up to 185 percent of the Federal poverty level (FPL). The demonstration is a private and public partnership between the Michigan Medicaid program and Blue Cross and Blue Shield of Michigan. Blue Cross and Blue Shield will administer the plan, generate private contributions from community sources to help pay service costs, and reimburse providers on the basis of the standard Blue Cross and Blue Shield fee schedule. The mainstream benefit package will include most primary and preventive ambulatory care but will exclude coverage of inpatient services.

Status: As of July 1, 1994, all children under 16 years of age with family income of less than or equal to 150 percent of FPL were made eligible for regular Medicaid and thus were no longer eligible for the demonstration. Reaching over 7,000 in late Summer 1994, enrollment in the program began to decline, finally stabilizing at around 4,000 by the beginning of 1995. On August 31, 1995, Federal participation in the program ended. Children continue to be served by CPC, which is now funded entirely through private donations and State appropriations.

94-133 Medicaid-Managed Care and Avoidable Hospitalization

Project No.:	18-C-90369/3
Period:	April 1995–March 1996
Funding:	$ 177,312
Award:	Cooperative Agreement
Principal Investigator:	Anne Marie Gadomaski, M.D., M.P.H.
Awardee:	Mary Imogene Bassett Hospital One Atwell Road Cooperstown, NY 13326
HCFA Project Officer:	Harry L. Savitt, Ph.D. Division of Health Information and Outcomes

Description: Since December 1991, the State of Maryland has required most categorically eligible Medicaid enrollees to participate in the Maryland Access to Care (MAC) Program. Under MAC, each Medicaid enrollee chooses (or is assigned) a primary medical provider, who provides case management services and acts as a gatekeeper for secondary and tertiary care. One objective of MAC is to improve access to primary and preventive care for the Medicaid population. In this evaluation, the awardee will seek to determine the effect of MAC on the number of avoidable pediatric hospitalizations. The analysis will be performed using hospital claims data from the Maryland Medical Assistance Program and the Maryland Health Services Cost Review Commission's hospital discharge database (HDD).

Status: The first tasks will be to verify the reliability of the HDD diagnosis codes by comparing them to sampled medical records and to select specific *International Classification of Diseases, 9th Revision, Clinical Modification* codes for analysis. Two quarterly reports (April 1, 1995–June 30, 1995 and July 1, 1995–September 30, 1995) have been received. Six years of HDD files (1989–1994) have been processed. Preliminary analyses have begun.

94-007 **Medicaid-Quality of Care: Primary Care, Episodic Care, and Expenditures for Selected Medical and Surgical Conditions in California, Georgia, and Michigan, 1991: Research File Development**

Project No.:	500-94-0029
Period:	June 1994–May 1995
Fnding:	$ 142,576
Award:	Contract
Principal Investigator:	Stephen H. Long, Ph.D.
Awardee:	The RAND Corporation 2100 M Street, NW. Washington, DC 20037
HCFA Project Officer:	M. Beth Benedict, Dr.P.H. Division of Health Information and Outcomes
Mandate:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509)

Description: This project is part of the research effort by the Health Care Financing Administration to respond to the congressional mandate (Public Law 99-509) to measure the quality of care rendered to Medicaid patients. The awardee will link Medicaid medical records data files with eligibility, claims, and provider files. The cases are a representative sample of enrollees in the California, Georgia, and Michigan Medicaid programs who had emergency room visits and hospitalizations for pediatric asthma, hysterectomies, and complicated labor and deliveries (both mothers' and newborns' records) in calendar year 1991. These cases originally were selected for the Medicaid Quality of Care Study.

Status: The project is completing the construction of the research files.

88-015 **Medicaid Quality of Care Study**

Project No.:	500-88-0044
Period:	June 1988–January 1994
Funding:	$ 5,874,673
Award:	Contract
Principal Investigator:	Nancy Merrick, M.D.
Awardee:	SysteMetrics, Inc. Santa Barbara Corporate Center 5425 Hollister Avenue, Suite 140 Santa Barbara, CA 93111
HCFA Project Officer:	M. Beth Benedict, Dr. P.H. Division of Health Information and Outcomes
Mandate:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509)

Description: Under section 9432(c) of Public Law 99-509, the Department of Health and Human Services is required to report to Congress on a study that examines quality of care: the necessity, appropriateness, and effectiveness of selected medical treatments and surgical procedures for Medicaid patients. The study is assessing the variation that exists in the rate of performance of selected treatments and procedures on Medicaid beneficiaries for small areas within and among States. The study is determining underutilized, medically necessary treatments and procedures for which failure to furnish could have an adverse effect on health status and for which the rate of use by Medicaid beneficiaries is significantly less than the rate for comparable, age-adjusted populations.

Status: Phase I analysis has been completed. The report, "Patterns of Health Care Utilization in the Nonelderly Medicaid Population of Selected States," accession number PB93-184836, was delivered to Congress and is available from the National Technical Information Service. Findings from this report indicate that the overall observed rate of inpatient utilization in the Medicaid population was substantially higher than the rate expected based on non-Medicaid utilization patterns. The difference was more pronounced for medical conditions than for surgical conditions. Some conditions exhibited patterns of utilization that make them likely candidates for further study:

- Pediatric bronchitis and asthma were consistently the highest volume medical conditions in the Medicaid population. The rate observed for these conditions was notably higher than the rate expected based on non-Medicaid utiliation patterns, and it exhibited high geographic variation within the Medicaid population.
- Hysterectomy was consistently one of the highest volume inpatient surgeries in the Medicaid population and in some cases exhibited notable variation from one geographic area to another.
- Pregnancy-related conditions were by far the major source of inpatient admission in the population under 65 years of age in Medicaid. The volume alone, as well as the higher rate of admission for post partum conditions in Medicaid, points to the need for further inquiry in this area.

The Phase II study is under way and involves reviewing medical records of patients who were hospitalized for three conditions important to the Medicaid population: pediatric asthma, hysterectomy, and complicated delivery. This contract was extended to complete the abstraction of the medical records. A separate contract was awarded to conduct the analysis.

88-016 **Medical Assistance Facility Demonstration Project**

Project No.:	95-C-99292/8
Period:	June 1988–July 1997
Funding:	$ 913,630
Award:	Cooperative Agreement
Principal Investigator:	Keith McCarty
Awardee:	Montan Hospital Research and Education Foundation P.O. Box 5119 Helena, MT 59604
HCFA Project Officer:	Siddhartha Mazumdar, Ph.D. Division of Delivery Systems and Financing
Mandates:	Section 4008(i)(1) of the Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508, amended by Section 13507 of the Omnibus Budget Reconciliation Act of 1993, Public Law 103-66)

Description: The Montana Hospital Research and Education Foundation (MHREF) is conducting a demonstration of the utility and desirability of medical assistance facilities (MAF), limited-service hospital models located in remote, rural frontier areas. The MAF is a new category of licensure in Montana for health care facilities providing emergency, outpatient, and low-intensity acute care services to short-term inpatients. MAFs are intended to maintain accessibility to basic acute and emergency care services and provide limited inpatient care for no longer than 96 hours. These facilities are located in counties with fewer than six residents per square mile or in areas more than 35 miles from the nearest hospital. MAFs maintain agreements with larger full-service hospitals and other providers to ensure the availability of a full network of services. In enacting section 4008(i)(1) of Public Law 101-508, Congress provided the authority to implement the demonstration. Section 13507 of the Omnibus Budget Reconciliation Act of 1993 amends this section of the law and extends the demonstration through July 1997. This project consists of two phases. Phase I (planning and development) addressed technical issues, including payment formula, services covered, and design of a project evaluation. Phase II is the implementation, operation, and evaluation of the demonstration.

Status: The MAF demonstration is the first time that limited-service hospitals have received Health Care Financing Administration certification to be reimbursed for the provision of inpatient services to Medicare beneficiaries. The project has served as a prototype in the development of the Essential Access Community Hospital program. HCFA and MHREF have worked to develop the MAF concept by defining service, staffing, and equipment capabilities at each of the demonstration sites. In addition, use and cost projections have been prepared to estimate the financial impact of the project on the facilities and on the Medicare program. HCFA and MHREF have developed conditions of participation and certification requirements, quality assurance and use review procedures, and payment systems for MAFs. The facilities are subject to rigorous utilization and quality review by the peer review organization (PRO), including preadmission and concurrent review of all inpatients, in addition to the PRO's normal retrospective review procedures. MAFs are reimbursed for the provision of all services on a reasonable-cost basis by the Medicare and Medicaid programs (Blue Cross and Blue Shield of Montana also participates in the demonstration by reimbursing MAFs on a reasonable-cost basis). During fiscal year 1991, the development aspects of the demonstration were completed and Phase II (demonstration) began. Seven MAFs are operating currently in Montana.

89-032 **Medicare Catastrophic Coverage Act Evaluation: Beneficiary and Program Impact**

Project No.:	500-89-0063
Period:	September 1989–September 1995
Funding:	$ 2,846,906
Award:	Contract
Principal Investigator:	David Kidder, Ph.D.
Awardee:	Abt Associates, Inc. 55 Wheeler Street Cambridge, MA 02138
HCFA Project Officer:	Feather Ann Davis, Ph.D. Division of Aging and Disability

Description: The contract comprises a series of research projects related to the analysis of Medicare benefit changes and Medicaid beneficiary expansions introduced by the Medicare Catastrophic Coverage Act (MCCA) of 1988. The analyses focus on the Medicare benefit changes in skilled nursing care and hospice care. The analyses also address the MCCA-introduced payment of Part A and Part B premiums, and the deductibles and copayments for low-income qualified Medicare beneficiaries by State Medicaid programs. Data on use in a private nursing home chain are studied, and nursing home episodes for Medicare beneficiaries are identified through a linking of Part A and Part B bills. Post-hospital use is studied through two tracer conditions—stroke and hip fracture. The Medicaid analyses primarily focus on the effects of the expansions for pregnant women and their infants. Analyses of birth and death records are conducted on national vital statistics data. Missouri birth and infant death data are linked with Medicaid eligibility and utilization data and analyzed for changes over time in Medicaid enrollment of pregnant women and the birth outcomes of their infants. Analysis of a year of infant health care utilization includes data from birth certificates and mothers' Medicaid eligibility. A trend analysis of

Massachusetts hospital discharge data focuses on shifts in Medicaid use, lengths of stay, severity of birth outcomes, and neonatal intensive care unit use before and after the MCCA legislation.

Status: The final report is due in early November 1995. The following reports have been submitted and are available:

- Coulam, R.F.: "Analysis of Massachusetts Births, 1984–1990: Evaluation of Medicare Catastrophic Coverage Act." Accession number PB93-112696, from the National Technical Information Service.
- Gavin, N.I: "Review and Synthesis of the Literature on Financial Barriers to Health Care Services for Children." February 21, 1992.
- Coulam, R.F.: "Literature Review: Prenatal Care and the Effects of Liberalizing Medicaid Eligibility." (draft) April 4, 1991.
- Abt Associates, Inc.: "The 1988 Expansion of Medicaid Eligibility for Pregnant Women in Missouri: Effects on Medicaid Enrollment, Prenatal Care Access and Birth Outcomes." August 1995.
- Coulam, R.F.: "Medicare Catastrophic Coverage Act Evaluation: The Expansion of Medicaid Eligibility for Pregnant Women in Missouri: Case Study: Final Report." January 30, 1995.
- Irvin, C.V.: "Medicare Catastrophic Coverage Act Evaluation: Missouri Infants Utilization and Reimbursements of Medicaid Financed Health Services After the Mandated Expansion of 1988." July 1995.
- Schmitz, R.J.: "Evaluation of the Medicare Catastrophic Care Act: Determinants and Benefits of Prenatal Care: An Analysis of the National Maternal and Infant Health Survey." January 1995.
- Irvin, C.V.: "Medicare Catastrophic Coverage Act Evaluation: The Receipt of Prenatal Care Services Across Different Medical Risks and Levels of Utilization Evidence from the 1988 National Maternal and Infant Health Survey." July 1995.
- Abt Associates, Inc.: "Medicare Catastrophic Coverage Act Evaluation: Medicaid Maternal and Child Health Generosity." September 1993.
- Cole, N.: "Increasing Access to Health Care: The Effects of Medicaid Expansions for Pregnant Women." January 1995.
- Banaszak-Holl, J. and Mor, V.: "The Impact of Changing Medicare Coverage on Hospice Beneficiaries." July 1995.
- Aizer, A.; Ozinkowski, R.J.; and Smith, G.: "Medicare Expenditures and Utilization Under the Qualified Medicare Beneficiary Program." January 1995.
- Berg, K., Mor, V. and Calore, K.: "The Impact of Changing Medicare Coverage on Nursing Home Episodes of Care." April 1995.

Two final reports summarize the findings of the various analyses presented in the reports listed above:

- Laliberte, L., Mor, V., Berg, K., Banaszak-Holl, J., Calore, K., Intrator, O., and Hiris, J., "Medicare Catastrophic Coverage Act Evaluation: The Impact of the Medicare Catastrophic Coverage Act on the Long-Term Care System." June 1995 (draft).
- Coulam, R.F., Cole, N., Irvin, C., Kidder, D., and Schmitz, R.J.: "Evaluation of the Medicare Catastrophic Care Act: Final Report." September 26, 1995 (draft).

Legislation Benefits: MCCA of 1988 included gap-filling and new benefits. It expanded and simplified hospital coverage effective January 1989, only to be repealed, effective January 1990. The legislation reduced beneficiary liability to one hospital deductible per year, eliminated the concept of "spell of illness," and eliminated the coinsurance calculations necessary under the original Medicare program. The legislation made the Part A Extended Care Benefit more generous by increasing the day limit on skilled nursing facility care from 100 to 150 days per year, and eliminated the prior 3-day hospital stay. The coinsurance requirements were revised, and the rate was lowered to 20 percent of the daily cost of nursing home care instead of being linked to the average cost of a day of hospital care. Also, the coinsurance was to apply only to the first 8 days of the stay, instead of applying to the 21st through 100th day. These changes meant that more beneficiaries would qualify for coverage and that longer stays would be covered. The skilled nursing facility changes went into effect in January 1989 and were rescinded, effective January 1990. Changes to the hospice benefit, implemented in January 1990 and rescinded in January 1990, eliminated the 210-day lifetime limit on hospice benefits, but retained a cost limit. None of the other Medicare benefits (Part A or Part B or Drug) of MCCA were implemented, having been scheduled for implementation after the date that the provisions were repealed.

The Medicaid provisions of the legislation were left intact, including the payment of Part B premiums, deductibles and copayments for qualified (poor) medicare beneficiaries, and mandatory Medicaid coverage for pregnant women and their infants with income of up to 100 percent of the Federal poverty level. (The coverage was phased in—75 percent by July 1989 and 100 percent by July 1990). The Coulam analysis of births, using Massachusetts hospital discharge data for the years 1984 through 1990, employs a birth-outcome grouping based on the *International Classification of Diseases, 9th Revision, Clinical Modification* codes, along with payer source. The analysis shows that the Medicaid share of all Massachusetts births increased from 14 percent in 1986 to about 19 percent in 1990; the largest relative decline was in the self-pay/free care/other category. The proportion of births covered by Medicaid increased slightly for all racial and income groups; however, increases in the share of Medicaid births were disproportionately large for the relatively advantaged groups. Differences in birth outcomes for the disadvantaged income groups do not show consistent improvement or

decline, compared with the advantaged groups. Hospital resource use during the birth episode declined over time. Patterns of utilization across income, race/ethnicity, and payer groups generally reflected the higher proportion of problem births experienced by disadvantaged groups. Persistent differences in the quality of birth outcomes by race/ethnicity, income, and payer remain after the Medicaid expansions.

89-028 Medicare Catastrophic Coverage Act Evaluation: Impact on Industry

Project No.:	500-89-0064
Period:	September 1989–September 1994
Funding:	$ 993,199
Award:	Contract
Principal Investigator:	Marilyn Moon, Ph.D.
Awardee:	The Urban Institute 2100 M Street, NW. Washington, DC. 20037
HCFA Project Officer:	Feather Ann Davis, Ph.D. Division of Aging and Disability

Description: The contract comprises a series of research projects assessing the effects of the benefit changes introduced by the Medicare Catastrophic Coverage Act (MCCA) of 1988 (Public Law 100-360) on relevant health care providers, specifically hospitals, nursing homes, and home health agencies.

Status: The evaluation is complete. Papers include the following:

- Liu, K. and Kenney, G.: "Impact of the Catastrophic Coverage Act and New Coverage Guidelines on the Medicare SNF Benefit." October 1991.
- Kenney, G.M. and Moon, M.: "Descriptive Analyses of Changes in Medicare SNF and Home Health Use." Washington, D.C., The Urban Institute, August 1992.
- Liu, K.; Taghavi, L.; and Cornelius, E.: "Changes in Medicaid Nursing Home Beds and Residents." October 1992.
- Dubay, L.C.; Norton, S.A.; and Moon, M.: "Hospital Uncompensated Care Burdens: National Trends and the Impact of the Medicaid Expansions." Washington, D.C., November 1993.
- Kenney, G.M. and Moon, M.: "Supply Changes in Medicare Home Health Care in the 1980s." October 1993.
- Kenney, G.M., and Moon, M.: "The Relationship Between Medicare Home Health and SNF Use After Implementation of the Medicare Catastrophic Coverage Act." Washington, D.C., April 1994.
- Kenney, G. and Moon, M.: "Medicare Subacute Care Services and Enrollee Characteristics." Washington, D.C., December 1994.
- Liu, K., Kenney, G., Wissoker, D., and Marsteller, J.: "The Effects of the Medicare Catastrophic Coverage Act and Administrative Changes on Medicare SNF Participation and Utilization: 1987-1991." Washington, D.C., June 1995.
- Moon, M., Dubay, L., Kenney, G., Liu, K., Marsteller, J., and Norton, S.: "Medicare Catastrophic Coverage Act Evaluation: Preliminary Analysis of Impact on Industry: Final Report." September 1995.

Findings: MCCA eliminated beneficiary Part A coinsurance and limited deductibles to one year, increasing Medicare's share of the costs of beneficiaries' hospital stays. Analyses concluded that MCCA decreased beneficiary out-of-pocket expenditures. Even though overall bad debt in hospitals increased, the bad debt for hospitals with the largest maternity load decreased, reflecting the impact of MCCA's Medicaid eligibility expansion for poor/pregnant women and their infants.

Between 1987 and 1992, the Medicare skilled nursing facility (SNF) benefit increased in overall costs, admissions, participating facilities, length of stay, and case mix. The growth in all of these areas made a small increase from 1987 to 1988; a large increase in 1989, the year MCCA was implemented; a large drop in 1990, the year the repeal went into effect; and steady increases in 1991 and 1992. Both the Medicare revised coverage guidelines and MCCA had major effects on the use of the Medicare extended care benefit, increasing both the number of Medicare residents in the facilities and the number of Medicare-certified facilities that actually served Medicare patients. Proprietary and larger nursing homes, rather than government-owned or smaller nursing homes, were most likely to begin accepting medicare patients. Homes with higher RN-to-bed ratios had greater increases in Medicare participation between 1987 and 1988, but smaller increases between 1988 and 1989. Higher initial Medicaid reimbursement levels seemed to induce nursing homes to serve Medicare patients in 1989. The increase in Medicare patients after the implementation of these policy changes was offset by a disproportionate decrease in private-pay patients, indicating that the policies increased the role of public financing for nursing home care.

Analyses of the changing home health market in response to MCCA and other regulatory changes suggest a complicated set of relationships and causal factors. Home health agencies substantially expanded the scope of services offered between 1983 and 1989, with urban areas offering more comprehensive services than rural settings. Although analyses found no offset between nursing home and home health utilization, they did show that larger increases in home health occurred in areas with higher Medicare discharges in diagnosis-related groups with high use of postacute care. Larger increases in home health use also occurred in areas with high proportions of dually eligible enrollees. Findings suggest that the service needs of new

Medicare beneficiaries are more likely to involve personal care rather than specialized care such as physical therapy or medical services. Much of the growth in home health care was associated with less skilled agencies. Between 1983 and 1989 the absolute number and the share of home health agencies run by voluntary nursing associations and standard nonproprietary agencies declined. Users of rehabilitation services seem to be similar to those using home health services across many dimensions. SNF users, in contrast, are older and more likely to be female and/or unmarried. The ratio of home health agencies per enrollee and nursing home bed moratoria had significant effects on use of health services.

95-049 Montana Welfare Reform: Families Achieving Independence in Montana (FAIM)

Project No.:	11-W-00040/8
Period:	February 1996–January 2004
Funding:	Waiver only
Award:	Waiver-only Project
Principal Investigator:	Peter S. Blouke, Ph.D.
Awardee:	Montana Department of Public Health and Human Services P.O. Box 4210 Helena, MT 59604-4210
HCFA Project Officer:	Joan Peterson Office of State Health Reform Demonstrations

Description: Statewide, this demonstration will establish (1) a Job Supplement Program consisting of a set of Aid to Families with Dependent Children (AFDC)-related benefits to assist individuals at risk of becoming dependent upon welfare; (2) AFDC Pathways Program, in which all applicants must enter into a Family Investment Agreement requiring parents to secure child support, obtain early, periodic screening, diagnosis and treatment (EPSDT) services and immunizations for their children, and participate in the State's Jobs Opportunity and Basic Skills program and limiting adults' benefits to a maximum of 24 months for single parents and 18 months for two-parent families; and (3) a community services program requiring 20 hours per week for individuals who reach the AFDC time limit but have not achieved self-sufficiency. Montana will expand Aid to Families with Dependent Children-Unemployed Parent (AFDC-UP) eligibility and increase the resource and automobile equity limits for AFDC and Food Stamp recipients. The State will also increase the dependent care disregard, as well as disregards of energy assistance payments, earned income of dependent children in school, gifts of money for special occasions, and child support payments made to non-household members for AFDC and Food Stamp purposes. Under its demonstration, enrollment of adult participants in a health maintenance organization (HMO) is mandated where geographically available. In areas where an HMO is not available, Montana would offer basic Medicaid coverage through Passport to Health, Montana's primary-care case-management program.

Status: The planned implementation date for this project is February 1996.

94-073 Multistate Analysis of Utilization, Expenditures, and Access to Care for Persons with Acquired Immunodeficiency Syndrome

Project No.:	500-92-0022DO04
Period:	September 1994–December 1996
Funding:	$ 490,114
Award:	Delivery Order in Master Contract
Principal Investigator:	Craig Thornton, Ph.D.
Awardee:	University of Minnesota (See page 209)
HCFA Project Officers:	Lawrence E. Kucken and Michael Kendix, Ph.D. Division of Health Information and Outcomes

Description: The objective of the project is to conduct a study on persons with acquired immunodeficiency syndrome (AIDS) and human immunodeficiency virus (HIV)-related diseases who are covered by a variety of financing mechanisms. In particular, the project will conduct a statistical investigation and will examine trends in enrollment, service use, and expenditure patterns of Medicare, Medicaid, and private insurance patients between 1990 and 1992. It will compare programs and assess differences in access to care. The project will provide more expansive and current data on use and expenditures related to AIDS and HIV health services.

Status: The file preparation phase of this project is nearing completion.

93-029 National Ambulatory Electrocardiographic Quality Assurance Program

Project Nos.:	97-P-08013/2-01 (Phase I) 97-P-08013/2-02 (Phase II)
Period:	February 1993–January 1994 (Phase I) February 1994–January 1995 (Phase II)
Funding:	$ 35,514 (Phase I) $ 100,364 (Phase II)
Award:	Grant

Principal Investigator: John J. DeCamilla, Jr.
Awardee: Scientific Associates
1349 South Street
Rochester, NY 14620
HCFA Project Officer: Carl S. Hackerman
Financial, Administrative, and Procurement Staff

Mandate: Small Business Innovation Development Act of 1982 (Public Law 97-219; as amended by the Small Business Innovation Research Program, Extension, Public Law 99-443)

Description: The goal of this project is to determine the feasibility of developing a national ambulatory electrocardiographic quality assurance program for physicians and for staffs of independent laboratories, clinics, and hospitals, all of whom provide these procedures.

Status: This project is in Phase II (testing and data gathering). Because the Small Business Innovation Research program sponsors the development of commercially viable products, it carefully protects the developer's intellectual property. Any detailed information on this project and the product must be obtained from the awardee.

95-062 Nebraska Welfare Reform Demonstration Project

Project No.: 11-W-0055/7
Period: July 1995–July 2002
Funding: Waiver only
Award: Waiver-only Project
Principal Investigator: Mary Dean Harvey
Awardee: Nebraska Department of Social Services
P.O. Box 95026
Lincoln, NE 68509-5026
HCFA Project Officer: Maria Boulmetis
Office of State Health Reform Demonstrations

Description: Statewide waivers permit the State to give no increase in cash benefits for a child born on welfare; increase resource limits; impose cash penalties when children do not attend school regularly; determine the Aid to Families with Dependent Children (AFDC) eligibility of minor parents living with adult parents by counting parental income in excess of 300 percent of the Federal poverty guideline; limit employable adults to a maximum of 24 months of AFDC and Medicaid in any 48-month period, and require employable adults to participate in employment-related activities, with more stringent sanctions for noncooperation. In this time-limited program, cases will receive cash in lieu of Food Stamps; two-parent families will have the same eligibility requirements as single-parent families; adults will choose to receive either the current AFDC cash grant and earnings disregard or a lower AFDC cash grant and higher earnings disregard; and cases who lose AFDC eligibility due to earnings will receive 24-month child care and Medicaid transition benefits. The Medicaid transition benefit will involve quarterly income reporting, with the case losing eligibility when income exceeds 185 percent of the Federal poverty guideline, and the State may impose cost sharing in months 7-24.

Status: The project is in its early implementation phase.

92-041 New Jersey Welfare Reform: Family Development Program

Project No.: 11-W-00016/2
Period: July 1992–September 1997
Funding: Waiver only
Award: Waiver-only Project
Principal Investigator: William Waldman
Awardee: New Jersey Department of Human Services, CN 700
Trenton, NJ 08625-0700
Project Officer: Alisa Adamo
Office of State Health Reform Demonstrations

Description: This demonstration has waivers from the Health Care Financing Administration and the Administration for Children and Families to do the following:

- Require that recipients of Aid to Families with Dependent Children (AFDC) in New Jersey participate in vocational assessment and counseling, if their youngest child is over 2 years of age, and impose financial penalties for nonparticipation.
- Allow children to remain AFDC eligible if the AFDC mother marries someone other than the natural father and the family income is below 150 percent of the Federal poverty level (FPL), but give no AFDC payment increase for any child born while a family is on welfare.
- Expand education and employment activities, and disregard more of initial earnings, while also allowing two-parent families to have the same earnings as single-parent families before losing AFDC eligibility.
- Allow these families who work their way off welfare to have a 24-month Medicaid extension, with no income limit during the extension period. (Current law provides a 6-month Medicaid extension, regardless of income, with an additional 6 months contingent upon earnings below 185 percent of the FPL.)

Medicaid waivers were required in order to implement the Medicaid transition benefit.

Status: The demonstration is being implemented. Approximately 20 percent of the AFDC population is participating in the Family Development Program.

93-017 Nursing Facility Management Software to Monitor Quality of Care

Project Nos.:	97-P-08003/6-01 (Phase I) 97-P-08003/6-02 (Phase II)
Period:	February 1993–January 1994 (Phase I) February 1994–January 1995 (Phase II)
Funding:	$ 34,760 (Phase I) $ 99,640 (Phase II)
Award:	Grant
Principal Investigator:	Robert C. Godbout, Ph.D.
Awardee:	Austin Data Management Associates P.O. Box 4358 Austin, TX 78765
HCFA Project Officer:	Carl S. Hackerman Financial, Administrative, and Procurement Staff
Mandate:	Small Business Innovation Development Act of 1982 (Public Law 97-219; as amended by the Small Business Innovation Research Program, Extension, Public Law 99-443)

Description: The goal of this project is to design personal computer software and training materials that would make quality of care information accessible and usable to nursing facility managers and others. The software would analyze resident outcomes, service patterns, and staffing to assist the user in monitoring the quality of care in nursing facilities and to suggest management decisions for improving quality.

Status: This project is in Phase II (testing and data gathering). Because the Small Business Innovation Research program sponsors the development of commercially viable products, it carefully protects the developer's intellectual property. Any detailed information on this project and the product must be obtained from the awardee.

92-057 Payment of Pharmacists for Cognitive Services

Project No.:	11-C-90229/0
Period:	September 1992–March 1995
Funding:	$ 721,588
Award:	Cooperative Agreement
Principal Investigator:	Dale Christensen, Ph.D.
Awardee:	State of Washington Department of Social and Health Services 623 Eighth Avenue, SE. Olympia, WA 98504-5510
HCFA Project Officer:	Kathleen Gondek, Ph.D. Division of Payment Systems
Mandate:	Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: The purpose of this demonstration project is to test the effect of paying pharmacists for cognitive services. The demonstration design includes 100 treatment and 100 control pharmacies that have volunteered to participate. In addition, a comparison group of 100 nonvolunteer pharmacies will be recruited. Washington State will reimburse pharmacists assigned to the treatment group for providing cognitive services that can be linked to a prescription problem and that involve a change in prescription, a decision not to dispense, or an extension of patient counseling. Pharmacists will receive $4 for an intervention of 6 minutes or less and $6 for an intervention of more than 6 minutes.

Status: This project was implemented on February 1, 1994. As of March 1995, over 10,000 cognitive service documents were received by the project team.

95-065 Pennsylvania Welfare Reform: Pennsylvania Pathways to Independence

Project No.:	11-W-00044/3
Period:	April 1995–March 2000
Funding:	Waiver only
Award:	Waiver-only Project
Principal Investigator:	Feather Houstoun
Awardee:	Pennsylvania Department of Public Welfare P. O. Box 2675 Harrisburg, PA 17105-2675
HCFA Project Officer:	Joan Peterson Office of State Health Reform Demonstrations

Description: In Lancaster County, participants enter into written agreements intended to move them to employment. In the third month of employment, recipient families receive a benefit consisting of an Aid to Families with Dependent Children (AFDC) payment plus the cash equivalent of the family's Food Stamp allotment; AFDC earned-income disregards and Food Stamp deductions have been replaced with a deduction of $200 plus 30 percent; resource limits have been increased from $2,000 to $5,000; and recipients may exclude the equity value of one vehicle up to $7,500, as well as tax refunds and deposits into educational and retirement accounts. Aid to Families with Dependent

Children–Unemployed Parent (AFDC-UP) eligibility and work activity requirements have been eliminated, and full-time students through age 20 may receive AFDC. Child-care providers receive direct payment to cover the cost of care up to the established local- market rate ceiling. Transitional child care and Medicaid are provided to families with earned income up to 235 percent of Federal poverty level and case management services for such families may continue for 12 months after assistance ends. Transitional Medicaid for cases closed due to receipt of child support has been extended to 12 months.

Status: This project is in the early implementation stage.

90-063 Post-Hospitalization Outcomes Studies

Project No.:	500-90-0046
Period:	September 1990–March 1996 September 1990–September 1991 (Design Phase) July 1992–September 1996 (Implementation Phase)
Funding:	$ 1,282,667 $ 152,286 (Design Phase) $ 1,130,381 (Implementation Phase)
Award:	Contract
Principal Investigator:	Robert L. Kane, M.D.
Awardee:	University of Minnesota School of Public Health Institute for Health Services Research D-351 Mayo Memorial Building 420 Delaware Street, SE., Box 197 Minneapolis, MN 55455-0392
HCFA Project Officer:	Joan L. Warren, Ph.D. Division of Health Information and Outcomes

Description: The Post-Hospitalization Outcomes Studies (PHOS), in collaboration with the Agency for Health Care Policy and Research, under an interagency agreement, will assess the long-term outcomes for elderly Medicare beneficiaries undergoing cholecystectomy and elective total hip replacement. Findings from these studies will help accomplish the following:

- Determine the types and rates of beneficial outcomes and complications in the post-hospital period.
- Determine the relationship between particular types or combinations of service and good/poor outcomes.
- Determine the impact of hospitalization-specific procedures on the progression of illness and health-functional status.
- Determine if patient satisfaction with hospitalization is related to long-term outcomes.
- Identify population subgroups or specific patient characteristics that are associated with high rates of post-hospitalization complications.

Status: The full study that includes 3,500 cases began in April 1994. Data for PHOS are obtained from telephone interviews with Medicare beneficiaries who have been recently hospitalized for the selected procedures, from medical records, and from Medicare claims data. Patients will be contacted 2 weeks, 6 months, and 12 months following discharge. Final data from the two conditions will be available in early 1996.

92-029 Program of Preconceptional Intervention for Women at Risk for Low-Birth-Weight Infants

Project No.:	11-C-90154/4
Period:	February 1992–May 1998
Funding:	$ 917,324
Award:	Cooperative Agreement
Principal Investigator:	Gary Crayton
Awardee:	Florida Agency for Health Care Administration 1317 Winewood Boulevard Building 5, Room 422 Tallahassee, FL 32399-0700
HCFAProject Officer:	Lori Teichman, Ph.D. Division of Health Information and Outcomes

Description: The project is designed to demonstrate and evaluate an innovative preconception intervention program using resource mothers who guide high-risk clients through risk reduction activities during home visits, stressing a healthy spacing of pregnancies. The evaluation will determine the program's effect on patient access and utilization of health care, participation in indicated community services, adaptation of health behaviors, and pregnancy outcomes.

Status: This project received Federal waivers to provide operation of services from June 1994 through May 1998. The fourth-year continuation was awarded in August 1995. As of June 1995, there were 132 women enrolled in the demonstration. It was originally estimated that 350 participants would be enrolled in the project by December 1995, indicating difficulties in recruiting clients in the service area of 10 counties in central Florida. The primary impediment to client recruitment has been attributed to increased use of managed care since 1993. The demonstration is limited to fee-for-service clients.

93-030 Prove the Feasibility of a Very High-Efficiency Pumping Mechanism for a Low-Cost, Lightweight, High-Quality Intravenous Pump

Project No.:	97-P-08019/1
Period:	February 1993–January 1995
Funding:	$ 98,079
Award:	Grant
Principal Investigator:	Charles Khuen
Awardee:	IV Systems, Inc. 131 Forest Street Winchester, MA 01890
HCFA Project Officer:	Carl S. Hackerman Financial, Administrative, and Procurement Staff
Mandate:	Small Business Innovation Development Act of 1982 (Public Law 97-219; as amended by the Small Business Innovation Research Program, Extension, Public Law 99-443)

Description: This project will build and test a high-efficiency pumping mechanism for a low-cost, high-quality intravenous pump.

Status: This project has completed Phase I (development). A final report has been received. The project is in Phase II (build and test). Because the Small Business Innovation Research program sponsors the development of commercially viable products, it carefully protects the developer's intellectual property. Any detailed information on this project and the product must be obtained from the awardee.

92-051 Quality of Care Among Cohorts of Medicaid Children

Project No.:	500-92-0058
Period:	September 1992–January 1995
Funding:	$ 59,149
Award:	Contract
Principal Investigator:	Jay H. Glasser, Ph.D.
Awardee:	Systems Management Associates 5427 Valkeith Houston, TX 77096
HCFA Project Officer:	Penelope L. Pine Division of Health Information and Outcomes

Description: The purpose of this project is to provide the Health Care Financing Administration with information on how differences between continuous and discontinuous Medicaid enrollment affect use and expenditure patterns for clinical conditions, and whether there are access and quality of care issues for cohorts of young Medicaid children. Emphasis is to be placed on the application of longitudinal methodologies and analysis of complex factors that determine health resource use, cost, and continuity of care within selected cohorts of children in California, Georgia, and Michigan.

Status: The final report has been received and is currently under review.

94-006 Quality of Care: Medicaid and Other Populations

Project No.:	500-94-0017
Period:	June 1994–February 1996
Funding:	$ 439,857
Award:	Contract
Principal Investigator:	Nancy Merrick, M.D.
Awardee:	SysteMetrics, Inc. Santa Barbara Corporate Center 5425 Hollister Avenue, Suite 140 Santa Barbara, CA 93111
HCFA Project Officer:	M. Beth Benedict, Dr. P.H. Division of Health Information and Outcomes
Mandate:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509)

Description: The purpose of the project is to analyze a medical records data set to assess medical necessity, appropriateness, and effectiveness (outcomes) of selected treatments and procedures in the Medicaid and privately insured populations in response to the congressional mandate (Public Law 99-509). The database includes records of emergency room and inpatient care for pediatric asthma, inpatient hysterectomy, and complicated labor and delivery (which includes mothers' and their newborns' records). A secondary data analysis is to be conducted of the outcomes of a sample of Medicaid pediatric asthma patients enrolled in managed care plans compared to a sample receiving care through regular fee-for-service arrangements. This contract builds on the Health Care Financing Administration's quality of care research agenda in the context of health care reform.

Status: The data are being analyzed.

91-059 Rates of Inpatient and Outpatient Shunt Procedures for End Stage Renal Disease Beneficiaries

Project No.: 99-C-98489/9
Period: August 1991–July 1993
Funding: $ 103,906
Award: Cooperative Agreement
Principal Investigator: Joel D. Kallich, Ph.D.
Awardee: The RAND Corporation
Health Sciences Program
1700 Main Street, P.O. Box 2138
Santa Monica, CA 90407-2138
HCFA Project Officer: Joel W. Greer, Ph.D.
Division of Health Information and Outcomes

Description: The most frequent cause of hospitalizations among end stage renal disease beneficiaries is the insertion, repair, or replacement of the vascular access device, or the shunt. The purpose of this study is to examine physician services for shunt procedures for their dialysis patients and to examine cost differences between inpatient and outpatient settings.

Status: The final report, "Patterns of Inpatient Physician Services for End-Stage Renal Disease Beneficiaries," by Joel Kallich, John Adams, and S.A. Rahman, has been received and is currently under review. Approximately 85 percent of shunt creations and 75 percent of shunt complications are treated in an inpatient setting. Black persons are over 50 percent more likely to have a shunt creation or complication. Diabetics have a relative risk of shunt creation 33 percent higher than for other causes of renal failure, presumably caused by the clinical complications of diabetes. The shunt creation rate was 36 per 100 dialysis beneficiaries during 1990. Total allowed charges for physicians in 1990 were $48.9 million. Inpatient covered charges for hospitalization, primarily for a shunt-related procedure, were $272.8 million.

94-121 Rural Health Care Transition Grant Evaluation

Project Nos.: 500-91-0075, 500-94-0011, 500-95-0032
Period: October 1991–February 1999
Funding: $ 2,619,225
Award: Contract
Principal Investigators: Craig Thornton, Ph.D., Valerie Cheh, Ph.D., Jeanette Bergeron
Awardees: Mathematica Policy Research, Inc.
P.O. Box 2393
Princeton, NJ 08543-2393
HCFA Project Officer: Siddhartha Mazumdar, Ph.D.
Division of Delivery Systems and Financing

Mandates: Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203)
Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239)

Description: Mathematica Policy Research, Inc. (MPR), has completed its monitoring of the fiscal years 1989, 1990, and 1991 grantees and is performing post award functions for FY 1992, 1993, 1994, and 1995 Rural Health Care Transition grantees, which include the following:

- Monitoring grantees to determine how grant funds are being spent.
- Maintaining an ongoing profile of the grantees' progress in planning and/or implementing the components of their programs.
- Reporting to the Health Care Financing Administration the results of the monitoring, the perceived needs of rural hospitals, and the evaluation of the projects and of the impact and effectiveness of the program.

These contracts individually focus on the monitoring and evaluation of the yearly grantee cohorts. All states, except Connecticut, Delaware, Massachusetts, New Jersey, and Rhode Island, participated in the rural health transition program. In accordance with the recent change of the authorizing legislation, MPR is currently producing annual reports on the grant program for submission to Congress. These reports present general status descriptions on the progress of the grantees, including what services they are providing with grant funds. In addition, the reports focus on special topics pertaining to the grantee hospitals and rural health issues in general (e.g., how hospitals in low-income areas survive financially and the contribution of mid-level practitioners to small rural hospitals.

Consistent findings from the MPR evaluation include the following:

- Local access to specific services has increased inasmuch as grant funding has produced a variety of new services that patients are using; however, overall utilization and services have been unaffected by the grant program.
- Problems have persisted in recruiting and retaining physicians.
- The closure rate for grantee hospitals is equivalent to the closure rate for small rural hospitals nationwide; the grant program generally has failed to produce consolidation and conversion among hospitals.

89-029 Rural Health Care Transition Grants Program

Period: September 1989–September 1995
Funding: $ 17.5 million
Award: Grants
HCFA Project Officer: William L. Damrosch
Division of Delivery Systems and Financing

Mandates: Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203, amended by section 6003(g)(1)(B) of the Omnibus Budget Reconciliation Act of 1989, Public Law 101-239)

Description: Congress appropriated $17.5 million in fiscal year (FY) 1995 to fund the Rural Health Care Transition Grants program. Funding for fiscal year 1995 provided grants for new awards in 1995, second-year funding for projects awarded in FY 1994, and third-year funding for projects awarded in 1993, as well as an independent evaluation. These grants will support a variety of innovative projects to strengthen the capability of small rural hospitals and their communities to provide high-quality care to Medicare beneficiaries. Under this grants program, eligible rural hospitals may request up to $50,000 per year for up to 3 years. Hospitals receiving awards requested funds to support activities in such areas as enhancing outpatient and/or emergency services, recruiting health professionals, and developing alternative service delivery systems (including rural health care networks) to provide care more effectively. Hospitals qualified for this program if they were non-Federal, not-for-profit, short-term, general acute-care hospitals located in rural areas (i.e., those currently being paid as rural hospitals under the Medicare hospital prospective payment system) and had fewer than 100 available beds (as defined in the Medicare Cost Report).

Status: On September 30, 1995, the Office of Research and Demonstrations within the Health Care Financing Administration (HCFA) made 65 new awards from 309 applications received. Each application was reviewed for technical merit by a panel of experts. Of the 65 awards in fiscal year 1995, 37 went to hospitals applying as individual facilities and 28 went to hospitals applying as part of a consortium (5 consortia). Of the grants awarded to hospitals in FY 1994 and FY 1993, 294 hospitals requested and received second-year and third-year continuation funding totaling $13.2 million. HCFA continues to contract with Mathematica Policy Research, Inc. to evaluate the program and to provide technical support in monitoring the program.

94-018 Study of the Natural History of End Stage Renal Disease in Persons with Diabetes

Project No.: 500-92-0021DO04
Period: July 1994–December 1995
Funding: $ 111,074
Award: Delivery Order in Master Contract
Principal Investigator: Robert J. Rubin, M.D.
Awardee: Lewin/VHI, Inc.
(See page 207)
HCFA Project Officer: Paul W. Eggers, Ph.D.
Division of Health Information and Outcomes

Description: This project will analyze the natural progression of end stage renal disease (ESRD) among persons with diabetes to acquire further knowledge about the risk factors associated with this progression. This will be accomplished by linking the second National Health and Nutrition Examination Survey with the ESRD Program Management and Medical Information System at the Health Care Financing Administration. The cumulative incidence of ESRD among persons identified as diabetic or having impaired glucose tolerance will be calculated and risk factors will be identified.

Status: Relevant variables have been identified, and creation of the files for matching has begun.

93-066 Uniform Clinical Data Set Algorithm Refinement Project

Project No.: 500-92-0024DO07
Period: September 1993–March 1995
Funding: $ 341,853
Award: Delivery Order in Master Contract
Awardee: The Urban Institute
(with SysteMetrics, Inc.)
(See page 208)
HCFA Project Officer: Robert P. Connolly
Health Standards and Quality Bureau

Description: The Uniform Clinical Data Set System (UCDSS) is a computerized decision support system being developed for use by peer review organizations (PROs) to evaluate the quality of health care data used to evaluate both medical necessity for acute care services and quality of care. Within the UCDSS employed by PROs, there are currently five distinct algorithm modules. Three of these are used for determining appropriateness of admission, the other two are quality modules that are based on generic quality screens and discharge status. The UCDSS is currently being piloted

in five States. The data collected by the system are used for individual case review by the pilot PROs. The software applies admission necessity and quality algorithms to the data for a particular case and either approves the case or marks (flags) it for physician review. As PROs develop quality improvement projects, UCDSS will become an important source of data for evaluating patient outcomes with respect to specific treatment criteria and the process of care related to a particular diagnosis. The purpose of this project is to refine the disease-specific module of the UCDSS—the Patient Care Algorithm System (PCAS) and quality flags/indicators for four disease processes. The PCAS components are clinical logic that is applied to the clinical data abstracted from medical records to determine whether further PRO review is needed. The disease process modules included in this scope of work are cardiac dysrhythmias (two groups), diabetes mellitus, urinary tract infection, and female breast cancer.

Status: The project has been completed and is currently under review.

92-066 **Utah Welfare Reform: Single Parent Employment Demonstration**

Project No.:	11-W-00019/8
Period:	September 1992–October 1996
Funding:	Waiver only
Award:	Waiver-only Project
Principal Investigator:	Kerry Steadman
Awardee:	Utah Department of Human Services P.O. Box 45500 Salt Lake City, UT 84145-0500
HCFA Project Officer:	Maria Boulmetis Office of State Health Reform Demonstrations

Description: This demonstration has waivers from the Health Care Financing Administration, the Administration for Children and Families, and the Department of Agriculture (Food Stamps). Under this project, to divert them from welfare, applicants for Aid to Families with Dependent Children (AFDC) who appear to have short-term need are given a one-time cash payment equivalent to 3 months of an AFDC grant and 3 months of Medicaid coverage in Utah. Those with longer term needs receive a cash equivalent of Food Stamps, regular monthly AFDC payments, and an incentive payment to participate in employment-related activities, with a larger financial deterrent for nonattendance. Those who become employed receive a higher disregard of earnings than current law allows, and those who work their way off welfare receive 12 months of Food Stamp cash equivalent and a 12-month Medicaid extension, with no income limit during the extension period. (Current law provides a 6-month Medicaid extension, regardless of income, with an additional 6 months contingent upon earnings below 185 percent of the Federal poverty level.)

Status: The State is continuing to implement the demonstration.

93-063 **Vermont Welfare Reform: Family Independence Project** (Formerly, Vermont Family Independent Program)

Project No.:	11-P-90238/1
Period:	July 1993–June 2001
Funding:	Waiver only
Award:	Waiver-only project
Principal Investigator:	Cornelius D. Hogan
Awardee:	Vermont Agency of Human Services 103 South Main Street Waterbury, VT 05676
Project Officer:	Alisa Adamo Office of State Health Reform Demonstrations

Description: This demonstration has waivers from the Health Care Financing Administration, the Administration for Children and Families, and the U.S. Department of Agriculture (Food Stamps). The demonstration requires single-parent cases in Vermont who have been eligible for Aid to Families with Dependent Children (AFDC) for more than 30 months and two-parent cases who have been eligible for AFDC for more than 15 months to participate in subsidized employment. Demonstration waivers also broaden AFDC eligibility for two-parent cases, require most parents of minors to live in a supervised setting, increase the disregard of earnings and assets in determining AFDC eligibility, permit disbursement of child support payments to the AFDC family, permit the State to give incentive payments to AFDC parents who successfully complete parenting education classes or other approved activities, and make income eligibility the same for AFDC and Food Stamps.

Medicaid waivers allow families who work their way off welfare to have a maximum 36-month Medicaid transition benefit, in quarterly increments, as long as the family's income is below 185 percent of the Federal poverty level (in lieu of current law's maximum 12-month Medicaid transition benefit).

Status: Demonstration waivers were implemented July 1, 1994.

95-063 **Virginia Independence Program**

Project No.:	11-W-0062/3
Period:	July 1995–June 2003
Funding:	Waiver only
Award:	Waiver-only project
Principal Investigator:	Kay Cole James
Awardee:	Virginia Department of Health and Human Services P.O. Box 1475 Richmond, VA 23212
HCFA Project Officer:	Maria Boulmetis Office of State Health Reform Demonstrations

Description: Statewide, the Virginia Independence Program will provide one-time diversion payments to applicants instead of Aid to Families with Dependent Children (AFDC); tighten jobs opportunity and basic skills training program sanction; require paternity establishment within 6 months; require minor parents to live with adult guardians; eliminate benefit increase for a baby born to a mother on welfare; require AFDC caretakers without a high school diploma to attend school; require child immunizations; increase resource limits; and give transitional child care and Medicaid benefits to cases losing AFDC eligibility for any reason, if they have no coverage through an employer group health plan and have incomes below 185 percent of Federal poverty guidelines (FPG). The Virginia Initiatives for Employment not Welfare would phase in statewide a program over 4 years that will assign participants to a work activity, within 90 days of benefit receipt; provide employer subsidies from AFDC plus the value of Food Stamps; time-limit AFDC benefits to 24 consecutive months; apply full-family AFDC cash sanctions for refusal to cooperate with work programs; increase earned income disregards up to FPG; and provide 12 months of transitional transportation assistance.

Status: The project is in its early implementation phase.

94-070 **Virginia Welfare Reform Demonstration**

Project No.:	11-W-00013/3
Period:	November 1993–October 1997
Funding:	Waiver only
Award:	Waiver-only Project
Principal Investigator:	Carol A. Brunty
Awardee:	Virginia Department of Social Services 8007 Discovery Drive Richmond, VA 23229-8699
HCFA Project Officer:	Maria Boulmetis Office of State Health Reform Demonstrations

Description: This demonstration has waivers from the Health Care Financing Administration and the Administration for Children and Families. The project increases the resource limit for housing and education and extends Aid to Families with Dependent Children eligibility to full-time students until they reach 21 years of age. It also changes the method of counting stepparent income. In addition, it permits adults who have been on welfare for at least 2 years to volunteer for jobs expected to pay $15,000 to $18,000 per year, with initial training stipends equal to the AFDC grant. Furthermore, the project establishes a child support insurance program for clients leaving AFDC because of earnings. Finally, the project extends the Medicaid and child care transition benefit periods to 36 months in four localities, and to 24 months elsewhere in the State; but cases lose eligibility in the second and third years of the transition benefit if their income exceeds 150 percent of the Federal poverty level.

Status: The State continues to implement the demonstration.

88-002 **Wisconsin State Welfare Reform Demonstration** (Formerly, Wisconsin Welfare Reform Demonstration)

Project No.:	11-W-00041/5
Period:	October 1987–July 1995
Funding:	Waiver only
Award:	Waiver-only Project
Principal Investigator:	Richard Lorang
Awardee:	Wisconsin State Department of Health and Social Services P.O. Box 7850 Madison, WI 53707-7850
HCFA Project Officer:	Maria Boulmetis Office of State Health Reform Demonstrations

Description: This demonstration had waivers from the Administration for Children and Families (ACF) and the Health Care Financing Administration permitting the following:

- Some persons receiving Aid to Families with Dependent Children (AFDC) to work 40 hours per week rather than the law's limit of 20 hours.
- Major changes in the disregard of earnings, with less being disregarded in the initial 4 months of work and more in the subsequent 8 months.
- A Medicaid extension of 12 months for recipients who lose AFDC eligibility because of earnings, regardless of income increases during the extension period. (The Family Support Act law provides a 6-month Medicaid extension, regardless of income, with an additional 6 months contingent upon earnings below 185 percent of the Federal poverty level.)

Wisconsin implemented its 12-month Medicaid extension in February 1989 experimentally, with a pre-Family Support Act control group receiving a 4- or 9-month extension of Medicaid. In April 1990, the State implemented the Medicaid waiver statewide, with no control group. Therefore, the initial evaluation contrasted a full 12-month Medicaid extension with a 4- or 9-month extension for earners who worked their way off welfare.

The evaluation found that there was no significant difference in AFDC caseload, overall AFDC costs, or earnings between cases who had received a 12-month Medicaid extension and those who had received only 4-or 9-months. However, 76 percent of the cases with a 12-month Medicaid extension, in contrast to 73 percent of those with 4- or 9-months, left welfare some time during the 14-month study period. Among these closed cases, 27 percent of those with a 12-month Medicaid extension returned to welfare within the study period, in contrast to 30 percent of those with a 4- or 9-month extension. The evaluators concluded that the longer extension did not provide an incentive for cases to leave AFDC, but did help to reduce welfare recidivism.

Status: The ACF waivers ended in July 1995. However, the State has requested an extension of the Medicaid waiver through September 1997. The request is currently under review.

92-042 **Wisconsin Welfare Reform: Two-Tier Aid to Families with Dependent Children Benefit Demonstration** (Formerly, Two-Tier Aid to Families with Dependent Children Benefit Demonstration)

Project No.:	11-P-90167/5
Period:	July 1992–January 1999
Award:	Waiver only
Principal Investigator:	Richard Lorang
Awardee:	Wisconsin State Department of Health and Social Services P.O. Box 7850 Madison, WI 53707-7850
HCFA Project Officer:	Maria Boulmetis Office of State Health Reform Demonstrations

Description: The project will measure the impact of Aid to Families with Dependent Children (AFDC) benefit levels on interstate migration among low-income families. This will be accomplished by paying families in up to six selected counties at a rate based on the benefit rate in their State of prior residence during their first 6 months in Wisconsin. Under the demonstration, a family will receive a benefit amount available to a typical family of the same size in the prior State of residence if the recipient applies for benefits within 180 days after moving to Wisconsin. A waiver of section 1902(c)(1), the maintenance of effort provision of the Medicaid law, has been approved to permit the State to obtain approvals of new State plans for medical assistance, even though the AFD payment levels under the project will be below those levels in effect as of May 1, 1988. In addition, under the authority of section 1115(a)(2) of the Social Security Act, the following expenditures will be regarded as expenditures under the State's Title XIX plan: expenditures to permit the State to maintain the eligibility level for its medically needy program at 133 1/3 percent of the current AFDC payment level, as specified under section 1903(f)(1), while the State reduces payments under the Two-Tier AFDC Benefit Demonstration.

Status: The State continues to implement the demonstration.

94-067 **Wisconsin Welfare Reform: Work Not Welfare**

Project No.:	11-W-00009/8
Period:	November 1993–December 2005
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Richard Lorang
Awardee:	Wisconsin State Department of Health and Social Services P.O. Box 7935 Madison, WI 53707-7935
HCFA Project Officer:	Maria Boulmetis Office of State Health Reform Demonstrations

Description: This demonstration has waivers from the Health Care Financing Administration, the Administration for Children and Families, and the Department of Agriculture (Food Stamps) to do the following:

- Consolidate the Aid to Families with Dependent Children grant and Food Stamps into a single cash payment.
- Provide no increase in the cash grant for children born on welfare.
- Limit cash benefits to 24 months in a 60-month period.
- Eliminate the restriction on hours of employment for two-parent families.
- Limit the family to 12 months of Medicaid and child care transition benefits within a 48-month period.
- Permit the State to require that recipients pay a premium for health insurance that exceeds 3 percent of their income during any part of the transition benefit period (current law limits this to the second 6 months of the 12-month transition period).

Status: The State continues to implement the demonstration.

Intramural

IM-057 Cancer Re-treatment Rate after Radical Prostatectomy in Patients Diagnosed with Clinically Localized Prostate Cancer

Funding: Intramural
HCFA Project Director: Grace L. Lu-Yao
Division of Health Information and Outcomes

Description: Radical prostatectomy is one of the most commonly used curative procedures for localized prostate cancer. However, the probability of requiring additional cancer treatment after this procedure is largely unknown. The objective of this study is to provide estimates regarding the likelihood of requiring additional cancer therapy after radical prostatectomy in geographically defined populations. This study was based on a linked data set that combined information from the Surveillance, Epidemiology, and End Results program and the Medicare hospital and physician claims. Patients were considered to have additional cancer treatment if there was evidence of radiation therapy, orchiectomy, and/or androgen deprivation therapy by injection. Overall, the 5-year cumulative incidence of having any additional cancer treatment after radical prostatectomy reached 34.9 percent. For patients with a pathological organ-confined cancer, the 5-year cumulative incidence of additional treatment ranges from 15.6 percent for well-differentiated cancer to 41.5 percent for poorly differentiated cancer. The corresponding figures for patients with pathologically regional cancer are 22.7 percent and 68.1 percent.

Status: The study was presented in the 1995 national conference of American Urological Association and American Federation of Clinical Research. Results will be published in the *Journal of National Cancer Institute* with the following citation: Lu-Yao, G.L., Potosky, A.L., Albertsen, P.C., Wasson, J.H.; Barry, M.J., Wennberg, J.E.: "Follow-up Prostate Cancer Treatments after Radical Prostatectomy: A Population-Based Study."

IM-038 Drug Patent Expirations and the Speed of Generic Entry

Funding: Intramural
HCFA Project Director: Jay Bae, Ph.D.
Division of Payment Systems

Description: When patents expire on prescription drugs, other firms may market chemically identical versions as generic drugs. This project examines the phenomenon of generic drug entry between 1987 and 1994. Recognizing the entry phenomenon as a dynamic process that occurs over time, this study evaluates the entry and nonentry cases in a duration model.

The estimation resulted in the following findings:

- There is a negative relationship between the innovative drug's sales revenue and the time to generic entry. In other words, the drugs that generate more revenue attract more rapid generic entries.
- The drugs that primarily treat chronic symptoms have quicker entries than the types of drugs that primarily treat acute illness.
- The generic entries became less likely and the time delay increased during the data period. This is a reversal of the trend observed between 1983 and 1987 by Grabowski and Vernon.
- Entry barriers for generic drugs seems to be non-monotonic in the number of existing branded products in a therapeutic market.

Status: The final report is under revision.

IM-004 End Stage Renal Disease Annual Research Report

Funding: Intramural
HCFA Project Director: Paul W. Eggers, Ph.D.
Division of Health Information and Outcomes

Description: The annual reports are designed to produce a wide range of data and analyses regarding the end stage renal disease (ESRD) program. Many of the data in these reports emphasize trends and comparisons over time, making these reports standard reference sources illustrating changes in the nature of the Medicare ESRD population and in the pattern of treatment of this population.

Status: The most recent published report is "Health Care Financing Administration: Research Report: End Stage Renal Disease, 1992." HCFA Pub. No. 03359. Bureau of Data Management and Strategy. Washington, DC. U.S. Government Printing Office, September 1994. Complimentary copies of this report are available from the Health Care Financing Administration, Bureau of Data Management and Strategy, Office of Systems Management, Division of Program Systems, N2-14-04, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. Telephone requests can be made to (410) 786-0069.

IM-055 Evaluating the Effects of Physician Payment Reform on Access: Time Series Analyses of Hospitalizations for Ambulatory Care-Sensitive Conditions

Funding: Intramural
HCFA Project Director: Thomas W. Reilly, Ph.D.
Division of Health Information and Outcomes

Description: This project evaluates the effects of physician payment reform (PPR) on access to care in the Medicare population by studying patterns of hospitalization for ambulatory care-sensitive (ASC) conditions. If there is a decrease in access to needed ambulatory care services associated with PPR, one would expect to see an increase in hospitalizations for ASC conditions following the implementation of PPR. This project will analyze the trend in rates of hospitalization for selected ASC conditions to see whether there is a discontinuity in the time series associated with the implementation of PPR.

Status: Analyses are nearing completion for the trend in hospitalizations for one ASC condition (congestive heart failure).

IM-032 Mammography Utilization Initiative

Funding:	Intramural
HCFA Project Director:	Anne E. Trontell, M.D.
	Division of Health Information and Outcomes

Description: Under the Consumer Information Strategy, the Health Care Financing Administration (HCFA) is seeking to increase the use of mammography services by elderly female beneficiaries. Mammography is particularly valuable in reducing breast cancer deaths among older women, who experience the highest incidence and mortality from breast cancer. HCFA data and national surveys indicate that biennial mammography use is far below the 60-percent figure proposed as a national health objective for the year 2000.

A year-long campaign to increase awareness and use of the Medicare mammography benefit was inaugurated May 1, 1995, by Hillary Rodham Clinton. A featured component of the campaign was a data book prepared by Office of Research and Demonstrations and the Bureau of Data Management and Strategy that contained age- and race-specific mammography use rates at the state and county level. Biennial rates for 1992–1993 were reported, as well as 1993 annual rates. This mammography data book was disseminated to public health and cancer organizations to help target outreach activities to areas with particularly low utilization.

Continued analysis of mammography use is anticipated on an annual basis, to help monitor the effectiveness of interventions to increase mammography use. Analyses of 1994 data have been initiated, and involve Central and Regional Office research staff.

IM-053 Monitoring Access to Physician Services Among Vulnerable Subgroups of the Medicare Population: Controlling for the Underlying Need for Services

Funding:	Intramural
HCFA Project Director:	Thomas W. Reilly, Ph.D.
	Division of Health Information and Outcomes

Description: A number of prior studies have attempted to evaluate access to physician services under Medicare by examining group differences in patterns of use. The problem with such analyses is that one often does not know whether differences in use reflect differences in access to care or differences in the underlying need for services. This project will isolate differences in access by comparing patterns of use within populations with comparable need for services. It will begin by examining the probability of obtaining followup care after a hospitalization for congestive heart failure. Since all such patients should receive a followup visit with a physician within 30 days, differences in followup care more clearly reflect differences in access rather than differences in the underlying need for services. The project will especially focus on whether potentially vulnerable subgroups are less likely to obtain needed care.

Status: The study is in the design phase.

IM-052 Monitoring Changes in Self-Reported Access to Care Among Medicare Beneficiaries

Funding:	Intramural
HCFA Project Director:	Thomas W. Reilly, Ph.D.
	Division of Health Information and Outcomes

Description: Efforts to monitor access in Medicare need to include information from beneficiaries on their experiences in obtaining care covered by the program. This study will examine data from the Medicare Current Beneficiary Survey on issues such as availability of care and perceived barriers to care. The study will track responses over time for the overall Medicare population and for potentially vulnerable subgroups.

Status: The study is in the design phase.

IM-054 Monitoring Needs Not Met by Medicare: An Examination of the Use of Noncovered Services Among Medicare Beneficiaries

Funding: Intramural
HCFA Project Director: Thomas W. Reilly, Ph.D.
Division of Health Information and Outcomes

Description: One important aspect of access to care for Medicare beneficiaries involves the extent to which needed services are, or are not, covered by the program. This project will monitor the use of noncovered services among Medicare beneficiaries, using data from the Medicare Current Beneficiary Survey. It will identify areas of high use/expenditure for the overall Medicare population and for potentially vulnerable subgroups. These analyses will help identify important gaps in Medicare coverage and identify subgroups of beneficiaries with relatively high levels of need for services not currently covered by the program. Tracking changes in patterns of use over time will help identify areas of growing need unmet by Medicare.

Status: The study is in the design phase.

IM-010 Monitoring Utilization of and Access to Services for Medicare Beneficiaries Under Physician Payment Reform

Funding: Intramural
HCFA Project Director: Ann Meadow, Sc.D.
Division of Payment Systems

Mandate: Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239)

Description: The Social Security Act, as amended by the Omnibus Budget Reconciliation Act of 1989, specified a new payment system for Medicare physicians' services. This intramural project is one of several analyzing effects of the new system on access to care. The work focuses on access impacts of the Medicare Fee Schedule (MFS) from the perspective of the physician. Although population-based use data can measure access as an outcome, such information does not explain the process by which physicians respond to policy change and thereby influence access. This project analyzed all available Medicare Part B claims from a panel of physicians identified by their Unique Physician Identification Number (UPIN). The first phase of the study analyzed 2 years of data (1991–1992) from a panel comprising 7,361 physicians in 18 selected States. The second phase analyzed 2 years of data (1992–1993) from a dynamic panel of approximately 18,000 physicians in 36 States, and included allowed charge data from 100 percent of physicians in 29 of those States. Additionally, the study examined 3-year trends in 15 States with claims data adequate for analysis back to 1991, which was the final year before implementation of the MFS. In both phases, the study's emphasis was on measuring change in several key access-related measures. The measures were caseload (i.e., number of beneficiaries treated in a year), continuity in performing specific procedures, total allowed charges, and assigned charges as a proportion of allowed charges.

Status: Initial findings were included in the "1994 Annual Report to Congress: Monitoring the Impact of Medicare Physician Payment Reform on Utilization and Access." Findings of the second phase were presented in the "1995 Annual Report to Congress" of the same title. The later phase showed that Medicare physician caseloads grew modestly in 1992 and 1993, the first 2 years of physician payment reform. The mean caseload rose 3 percent for physicians in the 36 areas analyzed. On average, a physician in 1992 had 322 Medicare patients, increasing to 333 patients in 1993. Only one State, Oregon, had a statistically significant decline in mean caseload (prob. < 0.05). Caseload change was analyzed according to the urbanization category of the physician's practice site. Statistically reliable growth was confined to some of the most urbanized groups. The study also examined caseload in relation to the fee changes introduced by the MFS pricing regime. We observed an inverse relationship between the State-level changes in caseload and the Health Care Financing Administration's forecast statewide average percent change in price. Deeper price cuts were associated with larger percentage increases in caseload. The 3-year analysis tended to show that, compared to the 1991–92 period, caseload growth slowed in the 1992–93 period. But it is not necessarily the case that 3-year trends, observed in 15 States, are indicative of the national experience. Average Medicare-allowed charge revenues changed little between 1992 and 1993 in most of the 29 States studied with 100 percent data. The overall average grew by $1,048, or about 1 percent. For the 17 States with allowed-charge data covering the 1991–93 period, we found that allowed charges either were flat in many places or stabilized after a 1991-92 decline. All racial groups experienced a favorable trend in assignment rates. Unlike the earlier phase of the study, which found little evidence of decline in the number of physicians participating in 45 categories of surgical and other procedures, the second phase found a broad drift downward in this indicator. Nine procedures exhibited a statistically significant decline, and only two categories showed a statistically significant increase (prob. < 0.01). The results were not explained by lower participation by assistants at surgery. In a few surgery categories, the decline could be attributed to such factors as known changes in clinical practice or in Medicare claims review practices. Because the pattern of surgery performance in relation to price changes was similar to the pattern for caseload (that is, performance rate change was inversely related to price change), we concluded that the MFS's price cuts did not prompt surgeons to turn away from Medicare, as some had feared.

IM-056 Nonresponse Bias in the Medicare Beneficiary Health Status Registry

Funding: Intramural
HCFA Project Director: Thomas W. Reilly, Ph.D.
Division of Health Information and Outcomes

Description: The Health Care Financing Administration is anticipating implementation of a survey to measure the health status of Medicare beneficiaries, called the Medicare Beneficiary Health Status Registry (Registry). It is important to understand differences between respondents and nonrespondents in such a survey. Using Medicare claims and enrollment data, this project will compare respondents and nonrespondents to the recently completed pilot test of the Registry. The study will examine factors such as patterns and types of hospitalization, ambulatory care service use, enrollment in managed care plans, and the like. The analysis will identify potential nonresponse bias that might be expected in the full Registry.

Status: The study is in the design phase.

IM-011 Organ Transplant Analysis

Funding: Intramural
HCFA Project Director: Lawrence E. Kucken
Division of Health Information and Outcomes

Description: This study analyzes the costs, use, and survival characteristics of Medicare patients having undergone heart, liver, and lung transplants during the 1987–92 period. The study focuses on the hospitalization in which the transplant was performed (using the Medicare provider analysis and review file), linked with pre- and post-hospitalization data from the Medicare Automated Retrieval System and the National Claims History File. Descriptive analyses will focus on demographic characteristics of transplant recipients. Transplant failure rates also are calculated. The linked record will be used to estimate total Part A and Part B utilization and Medicare payments associated with these transplant procedures.

Status: A draft manuscript describing transplant patient characteristics and associated hospital costs has been prepared and is under review.

IM-012 Patterns and Outcomes of Cancer Care in the Medicare Population

Funding: Intramural
Project Directors: Gerald F. Riley, James D. Lubitz, and Renee Mentnech
Division of Health Information and Outcomes

Description: More than one-half of all cancer patients have Medicare coverage. A database that links Medicare data with cancer registry data collected through the National Cancer Institute's Surveillance, Epidemiology, and End Results (SEER) program has been created. The SEER program covers approximately 10 percent of the U.S. Population. This database contains information on the anatomic site of the primary cancer, histology, stage of the disease at diagnosis, and date of diagnosis for each new case of cancer in the program's geographic areas. Linking SEER and Medicare data provides opportunities for research on issues of access to medical care, Medicare costs incurred by cancer patients, and patterns of medical care received by cancer patients diagnosed with various sites, stages, and histologies of cancer. Some specific questions to be addressed are the following:

- What are overall Medicare costs, by type and stage of cancer?
- What are the Medicare costs that are specifically related to cancer care?
- What comorbidities are associated with cancer and how do they influence Medicare use and cost?
- What is the mix of care (on a per person basis) among community hospitals, teaching hospitals, and cancer centers?
- What are the institutional factors that influence the type of inpatient hospital care received by cancer patients?

Status: SEER and Medicare data have been linked for nine registries for all cases diagnosed from 1973 to 1989. The following article has been published describing the linked database: Potosky, A.L., Riley, G.F., Lubitz, J.D. et al.: "Potential for Cancer-Related Health Services Research Using a Linked Medicare Tumor-Requesting Data Base." *Medical Care*, 31:732-747, 1993. The SEER-Medicare linkage is currently being updated to include cancer cases diagnosed through 1993 and will contain data from all 10 SEER registries.

Studies examining the patterns and outcomes of care for several different cancer sites are in progress.

IM-045 Prostate Cancer Care and Outcomes Among Medicare Beneficiaries

Funding: Intramural
HCFA Project Director: Grace L. Lu-Yao
Division of Health Information and Outcomes

Description: The objectives of this project include: (1) estimating the re-treatment rates in patients undergoing radical prostatectomy for prostate cancer; (2) describing the survival patterns following different initial cancer therapies in men diagnosed with clinically localized prostate cancer; and (3) evaluating the patterns of prostate cancer screening, treatment, and outcomes in recent years.

Status: The research addressing the first objective has been completed and it was presented at the national conference of the American Urological Association and the American Federation of Clinical Research. The analytical work for the second objective is also complete. A paper describing the results of the study is being prepared. Currently, we are working on data extraction to create an analytical file for the third objective.

IM-026 Racial Disparities in Coronary Artery Bypass Graft Surgery and Percutaneous Transluminal Coronary Angioplasty Use: A Socioeconomic Effect?

Funding:	Intramural
HCFA Project Director:	Renee Mentnech Division of Health Information and Outcomes

Description: Numerous studies have documented large racial differences in the rates of use of coronary care procedures. To determine the extent to which these findings reflect differences in the levels of insurance coverage and socioeconomic status, this study examines the rates of coronary artery bypass graft (CABG) surgery and percutaneous transluminal coronary angioplasty (PTCA) use in the population covered by both Medicare and Medicaid (for which Medicaid eligibility is based on income).

Status: The Medicare enrollment files for 1991 and 1992 were used to identify the study population. The Medicare provider analysis and review files for 1991 and 1992 were used to determine the number of CABGs and PTCAs. After calculating use rates by race and gender, the rates were adjusted for prevalence of coronary artery disease.

IM-024 Rehabilitation Facilities and Units: Utilization, Cost, and Payment

Funding:	Intramural
HCFA Project Director:	William Buczko, Ph.D. Division of Payment Systems

Description: This project is examining use and financial trends in the Medicare prospective payment system (PPS)-excluded freestanding facilities and units in inpatient hospitals. Issues related to the creation of a PPS for inpatient rehabilitation providers also are examined.

Status: This project has been examining MedPAR and Hospital Cost Report Information System data to develop a description of the utilization and cost trends in PPS-excluded rehabilitation facilities and units. This project has examined issues related to the development of a system for measuring case-mix variation in inpatient rehabilitation populations and other issues related to the creation of a PPS for reimbursement of Medicare inpatient rehabilitation care. These activities will continue into FY 1996. Papers using analyses from this project have been presented at the 1994 Annual Meeting of the American Public Health Association and the 1995 Annual Meeting of the Association for Health Services Research.

IM-046 Study of Access to Durable Medical Equipment by Non-Aged Disabled Medicare Beneficiaries

Funding:	Intramural
HCFA Project Directors:	William D. Clark Division of Aging and Disability

Description: This project is examining access to Durable Medical Equipment, especially wheelchairs, by non-aged disabled Medicare beneficiaries to determine whether changes in access have resulted from DME payment changes in the Medicare program. The study will utilize Medicare data from 1991 through 1995 to assess changes in assignment rates, payment denials, and supplier characteristics and other variables.

Status: A project design and data request are being prepared for review. Initial discussions with industry and advocacy group representatives have been held.

IM-042 The Effects of Insurance on Medical Spending Growth and the Determinants of Insurance Coverage

Funding:	Intramural
HCFA Project Directors:	Edgar A. Peden, Ph.D. and Mark S. Freeland, Ph.D. Division of Payment Systems and Office of National Health Statistics

Description: This project uses National Health Account data (1960 to 1993) to examine the effects of aggregate insurance coverage (the percentage of medical spending covered by third parties) on technology and real per capita medical spending growth in the United States. As a followup, it examines the determinants of insurance coverage itself. Results from the project have been used by the Health Care Financing Administration's Office of the Actuary to assess the effects of various policy alternatives regarding coverage and medical spending.

Status: The project has produced theoretical and empirical results regarding the impact of insurance coverage and other factors on medical spending growth. These results have been published in *Health Affairs*, summer 1995, as a Data Watch item entitled "A Historical Analysis of Medical Spending Growth, 1960-1993." Work is continuing on a technical version of this study, and work on the determinants of insurance coverage is just beginning.

IM-017 Trends in Access to Health Care Services for Selected Segments of the Medicare Population

Funding: Intramural
HCFA Project Director: Renee Mentnech
Division of Health Information and Outcomes

Description: Trend data on access to health care services will be developed for the years prior to, during, ad after implementation of physician payment reform (PPR). The focus will be on vulnerable subgroups of the Medicare population such as persons with low income, persons without supplemental medical insurance, and persons with acute and chronic conditions. Geographic differences also will be examined. These trend data will be derived from the National Health Interview Survey conducted by the National Center for Health Statistics. The years 1984, 1986, 1989, 1990, and 1991 will be used to develop pre-PPR baseline data. The years 1992 and 1993 will be used to develop post-PPR data.

Status: Descriptive data for 1984, 1986, 1989, 1990, 1991, and 1992 have been developed by sociodemographic characteristics. Relative standard errors have been computed by using a software package that takes complex sample designs into account. A multivariate model with 1984, 1986, 1989, 1990, 1991, and 1992 data has been developed to assess the impact of specific factors on use of physician services. Analysis of these data was incorporated into the 1993, 1994, and 1995 Reports to Congress on Access to Physician Services. The 1993 Health Interview Survey data will be added to the analyses as soon as they become available.

IM-025 Upper Gastrointestinal Endoscopy in the United States: Geographic Variation in Practice Patterns

Funding: Intramural
HCFA Project Director: Renee Mentnech
Division of Health Information and Outcomes

Description: Upper esophagogastroduodenoscopy (EGD) is a commonly performed procedure with well-defined indications. However, little is known about the practice patterns for this procedure, specifically the number performed. The purpose of this study is to examine variations in the use of endoscopy on Medicare patients in the United States and how variations in endoscopy rates relate to variations in the rates of hospitalizations for gastrointestinal disorders. Use of upper gastrointestinal X-rays will also be incorporated into the analysis to determine whether these two services are being used as substitutes for each other.

Status: All aged Medicare patients who underwent EGD and upper gastrointestinal X-ray in 1993 were identified by using Current Procedural Terminology codes. Rates of endoscopy and upper gastrointestinal X-ray for the top 50 metropolitan statistical areas by gender and race are being developed. Hospitalization rates for diagnoses for which an EGD is indicated are also being compared. The supply of gastroenterology training programs for physicians is being examined to determine the affect on utilization. A paper is being prepared.

Extramural

93-049 Analysis of Expansion of Access to Care Through the Use of Telemedicine and Mobile Health Services

Project No.:	500-92-0046DO02
Period:	June 1993–February 1995
Funding:	$ 264,259
Award:	Delivery Order in Master Contract
Principal Investigator:	Robert E. Schlenker, Ph.D.
Awardee:	Center for Health Policy Research (See page 204)
HCFA Project Officer:	William L. England, Ph.D., J.D. Division of Health Information and Outcomes

Description: This project was undertaken to analyze issues associated with telecommunications technologies for health care delivery (telemedicine) as they relate to the development of Medicare coverage policy. Study objectives included assessing the safety and effectiveness of telemedicine and recommended policies for payment, utilization review, and quality assurance. The report has five sections: (1) a comprehensive literature review; (2) a case study based on eight in-depth site visits; (3) an analysis of coverage policy of other third-party payers; (4) a final report that summarizes the first three sections; and (5) a paper that summarizes coverage and payment policy recommendations.

The study reports that early in 1993, there were between 10 and 15 operational telemedicine programs in the country, exclusive of teleradiology applications. By the end of 1994, there were an estimated 25 to 30 active programs, and 40 to 50 under development. However, the volume of telemedicine services actually delivered has been low, with many well-established programs reporting only 2 to 5 contacts per week. The study concludes that although the literature on effectiveness remains scarce, it may be appropriate to proceed with limited reimbursement for telemedicine services. The study strongly recommends conducting a cross-cutting evaluation of multiple telemedicine programs to assess utilization, cost, outcomes, and possible unanticipated consequences of telemedicine prior to Health Care Financing Administration implementation of a telemedicine coverage policy.

Status: The report has been submitted to the National Technical Information Service and is available for $27 (paper) or $12.50 (microfiche), plus $3 handling, accession number PB95-252813.

92-092 Analysis of Informal and Formal Care (Formerly, Long-Term Care Studies (Section 207))

Project No.:	500-89-0047/35
Period:	June 1992–December 1995
Funding:	$ 93,700
Award:	Contract
Principal Investigator:	David Kennell
Awardee:	Lewin/VHI, Inc. (See page 148)
HCFA Project Officer:	Carolyn Rimes Division of Aging and Disability

Description: The purpose of this study is to determine whether formal care substitutes for or complements informal care. To determine the relationship between formal care and informal care, a data set generated by the case-management agency Connecticut Community Care, Inc. (CCCI) is analyzed. CCCI conducts patient assessments of all publicly supported long-term care patients in Connecticut. This data set offers a unique opportunity to conduct an in-depth longitudinal analysis of the effect of providing formal care on the provision of informal care for a large population of elderly persons. Although surveys have repeatedly found that older persons strongly prefer community services to services offered in nursing homes, policymakers have resisted a major expansion of home care services even though community services are usually less expensive than nursing-home services. Perhaps the most important reason for this resistance is the fear that a publicly funded home care program will encourage family caregivers of the elderly to substitute formal care for informal care.

Status: This project is complete and is part of the proceedings from the Brookings Conference.

94-052 Availability and Effective Use of Pediatric and Family Nurse Practitioners Under State Medicaid Programs

Project No.:	18-C-90310/4-01
Period:	September 1994–December 1995
Funding:	$ 152,002
Award:	Cooperative Agreement
Principal Investigator:	Dale C. Jones, Ph.D.
Awardee:	Research Triangle Institute 3040 Cornwallis Road Research Triangle Park, NC 27709
HCFA Project Officer:	Penelope L. Pine Division of Health Information and Outcomes

Description: The primary objectives of this study are to assess the availability of family and pediatric nurse practitioners to provide services to the Medicaid population and to describe the extent to which nurse practitioners are currently caring for Medicaid patients. The main sources of data will be two national surveys of advanced practice nurses, conducted in the early 1990s.

Status: There are four studies in preparation for this project. Three of these papers are concerned with defining and describing the role of advanced practice nurses (APNs). The fourth paper addresses the issue of how the competence of APNs can be ensured in developing a mechanism for reimbursing APNs.

94-065 Bundle Payment for Physician and Hospital Services Using Telemedicine Services

Project No.:	95-C-90384/3
Period:	July 1994–July 1997
Funding:	$ 993,310
Award:	Cooperative Agreement
Principal Investigator:	William W. Reeves
Awardee:	West Virginia University Research Corporation Office of Sponsored Programs P.O. Box 6845 Morgantown, WV 26506-6845
HCFA Project Officer:	William L. England, Ph.D., J.D. Division of Health Information and Outcomes

Description: This project is investigating whether changing the current Medicare payment policy for telemedicine enhances patients' access to care and improves the quality of care delivered in rural communities, while limiting the growth of health care spending. West Virginia University's Mountaineer Doctor Television (MDTV) program currently links five rural spoke sites (Davis Memorial Hospital, Wetzel County Hospital, Grant Memorial Hospital, Boone Memorial Hospital, and St. Joe's Hospital) with two hub sites (the Robert C. Byrd Health Sciences Center in Morgantown and Charleston Area Medical Center). While hospital and administrative expenses are covered under the cooperative agreement award funding, payment for related physician services is expected to be made under a demonstration waiver of Medicare payment regulations. The major objective of the project is development of a payment system for inpatient telemedicine consultations. Related objectives include development of a coding system for inpatient telemedicine consultations, increasing the number of inpatient telemedicine consultations, and reducing interhospital transfers by 50 percent. The effect of the payment system on the number and types of charges generated by Medicare patients at rural MDTV sites will be evaluated. The cost effectiveness and feasibility of telemedicine followup for patients returned from the referral center to the rural hospitals for the remainder of their hospitalization will be evaluated. A plan for payment of outpatient telemedicine consultations also will be developed.

Status: This project is still being developed. Full-scale utilization of the system awaits Medicare demonstration waiver authority for providers to bill for medical services delivered to Medicare beneficiaries.

94-108 Congestive Heart Failure Outreach Project

Project No.:	18-P-90365/5
Period:	September 1994–September 1997
Funding:	$ 830,395
Award:	Grant
Principal Investigator:	Joseph P. Malone, M.D.
Awardee:	Miami Valley Hospital One Wyoming Street Dayton, OH 45409
HCFA Project Officer:	Renee Mentnech Division of Health Information and Outcomes

Description: Miami Valley Hospital is a large hospital in Ohio with 811 beds. This hospital, in cooperation with Wright State University-Miami Valley School of Nursing, will analyze whether post-hospital education and intensive case management can reduce rehospitalization rates for congestive heart failure (CHF) patients. All patients admitted to the hospital with a CHF diagnosis and discharged to a home will be assigned to case management followup or to standard post-hospital care.

Status: Recruitment of patients began in January of 1995. The data systems have been tested and are fully operational. Through June 30, 1995, 156 patients were identified as potential subjects. Of these, 69 agreed to participate and met the eligibility criteria. Patient recruitment is continuing.

91-088 Coordinating Care for Pregnant Substance Abusers Demonstration: Maryland

Project No.:	11-C-06103/5
Period:	September 1991–December 1996
Funding:	$ 1,300,000
Award:	Cooperative Agreement
Principal Investigator:	Mary E. Stuart, Sc.D.
Awardee:	Maryland Department of Health and Mental Hygiene 201 West Preston Street, Room 225 Baltimore, MD 21201
HCFA Project Officer:	Lori Teichman, Ph.D. Division of Health Information and Outcomes

Description: This project targets pregnant substance abusers who reside in specific areas in eastern Baltimore City. The project will demonstrate the costs and effectiveness of two innovative methods of outreach for Medicaid-eligible substance abusers. The first strategy makes use of aggressive clinical case management to link medical and substance abuse service. The second strategy is to test the substance abuse support group that meets twice weekly on site in the Johns Hopkins Hospital Prenatal Care Clinic. The project does not require waivers. Participants can receive targeted case management under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, permitting targeted case management to Medicaid recipients.

Status: Although service delivery began in 1993, enrollment rates have been lower than anticipated. Four hundred and sixty subjects were to be enrolled in the project over 3 years. In the first 2 years of service delivery, a total of 91 women were enrolled in the project and were receiving services. In response to the low rate of client recruitment, a second community-based organization was chosen to promote the identification and referral of eligible women from the catchment area into the demonstration.

91-087 Coordinating Care for Pregnant Substance Abusers Demonstration: Massachusetts

Project No.:	11-C-06111/5
Period:	September 1991–December 1996
Funding:	$ 1,125,000
Award:	Cooperative Agreement
Principal Investigator:	Dennis McCarty
Awardee:	Massachusetts Department of Public Welfare 180 Tremont Street, 13th Floor Boston, MA 02111
HCFA Project Officer:	Lori Teichman, Ph.D. Division of Health Information and Outcomes

Description: The focus of this project is to enhance current service linkage and delivery efforts in the Boston and Holyoke areas. The Massachusetts project, referred to as the MOTHERS project, consists of two interrelated yet distinct studies. Study One, which operated until January 1994, addressed strategies for identifying and bringing Medicaid-eligible pregnant substance abusers into prenatal care and substance abuse treatment. The project drew heavily on a prenatal care initiative referred to as the Perinatal Community Initiatives Project (PCIP), which, prior to State reorganization of the program, included community outreach and case finding, comprehensive case management for high-risk women, and linkage with other relevant services. A study is now being conducted of PCIP personnel to determine barriers and potential conflicts when using indigenous individuals for projects in similar communities. Study Two, the ongoing study funded by the Health Care Financing Administration, compares free-standing and hospital-based substance abuse detoxification and treatment in residential and outpatient settings.

Status: The project received waiver approval for the period July 1, 1993, through June 30, 1996. Screening is being conducted in the PCIPs and followup interviews are being conducted for women who have received detoxification, followed by residential or ambulatory treatment services. Based on the current participant recruitment frequency (45/quarter), and the 6 months remaining for recruiting pregnant women into the project, approximately 660 women will institute the final study population, about 20 percent less than the original anticipated number of 864.

91-086 Coordinating Care for Pregnant Substance Abusers Demonstration: New York

Project No.:	11-C-06115/5
Period:	September 1991–December 1996
Funding:	$ 1,700,000
Award:	Cooperative Agreement
Principal Investigator:	Barbara McManaman
Awardee:	New York State Department of Social Services Division of Medical Assistance 40 North Pearl Street Albany, NY 12243-0001

HCFA Project Officer:	Bonnie M. Edington Division of Health, Information and Outcomes

Description: The project has six sites, three in New York City and three in upstate New York. Approximately 450 eligible women were to be targeted for services. As adjuncts to the standard substance abuse treatment services, the following services will be provided: perinatal care, pediatric care, developmental screening, health education, family planning, parenting education, nutritional counseling, child care, vocational assessment, self-esteem building, and transportation. The project will include residential treatment programs.

Status: The project has received waiver approval for a 3-year period, beginning July 1, 1993, through June 30, 1996. There are six sites in the demonstration (three in downstate New York, in the metropolitan area; three in upstate New York). For the period of July 1993 through June 1995, there were a total of 319 participants; of the downstate/city sites, there were 85 persons in the Bronx, 33 in Manhattan, and 27 in Brooklyn. In the upstate New York sites, there was a total of 174 persons, wherein 60 persons were unaffiliated, 69 were in Buffalo, 7 were in Newburgh, and 38 were in Syracuse. The recruitment of clients in the three downstate metropolitan sites has been relatively low throughout the demonstration. In order to encourage provider participation, New York has changed the reimbursement rate for residential providers and is attempting to revise the rates for ambulatory providers. The State stopped new enrollment and recruitment in September 1995.

91-085 Coordinating Care for Pregnant Substance Abusers Demonstration: South Carolina

Project No.:	11-C-06112/5
Period:	September 1991–December 1996
Funding:	$ 1,441,000
Award:	Cooperative Agreement
Principal Investigator:	Eugene A. Laurent, Ph.D.
Awardee:	South Carolina State Health and Human Services Finance Commission P.O. Box 8206 Columbia, SC 29202-8206
HCFA Project Officer:	Lori Teichman, Ph.D. Division of Health Information and Outcomes

Description: The South Carolina "Transitions" project was implemented in the Edisto Health District, a tri-county area in the central part of the State that includes Calhoun, Orangeburg, and Bamberg counties. The three major components of the project are outreach, perinatal/substance abuse clinical services, and evaluation. Other services to be provided include focused maternal outreach using trained outreach workers, hospital-based detoxification and residential treatment, intensive in-home services, transportation, child care, child developmental assessments, and other support services. The South Carolina State Health and Human Services Finance Commission developed and finalized a reorganization of the clinical, outreach, and administrative components of the program after the substance abuse service provider suddenly suspended treatment services. The Department of Alcohol and Other Drug Abuse Services will be vested with program oversight for alcohol/drug treatment, street and community outreach, and local interagency coordination activities. The transfer will promote improved clinical/medical management and increase the quality and consistency of care provided. The State estimates that approximately 250 women and their infants will receive services during the operational phase of the demonstration.

Status: The project has received waiver approval for a 3-year period (July 1, 1993, through June 30, 1996). As of September 1995, 59 confirmed pregnant substance abusers and their children had received services. Low recruitment is attributable to the legal requirement to report pregnant substance abusers with positive urine screens to the State's Office of Child Protective Services. If the residential treatment facilities are unable to house the clients' children, then the children are removed. By contrast, only 50 percent of the children will be removed from nonenrolled group of pregnant substance-abusing clients.

91-096 Coordinating Care for Pregnant Substance Abusers Demonstration: Washington

Project No.:	11-C-06108/5
Period:	September 1991–December 1996
Funding:	$ 1,125,000
Award:	Cooperative Agreement
Principal Investigator:	Kathy Apadoca
Awardee:	Washington State Department of Social and Health Services Office of First Steps Mail Stop OB-45A Olympia, WA 98504
HCFA Project Officer:	Lori Teichman, Ph.D. Division of Health Information and Outcomes

Description: The Yakima First Steps Mobilization Project for Substance Abusing Pregnant Women: First Steps Plus is being conducted in Yakima county, the seventh largest county in the State. Yakima county was selected because of its high prevalence of substance abuse, and because the proportion of Medicaid-eligible women is higher than the

norm for the State. The First Steps Plus project provides a continuum of care for low-income, pregnant substance abusers. Medicaid maternity care services provided through Washington's First Steps program are combined or coordinated with chemical addiction treatment and social services. Project services are provided throughout pregnancy and delivery, and for up to 1 year after delivery. The project expands the range of Medicaid services and increases coordination of the service delivery community through communication, collaboration, and training. Additional Medicaid services being provided to the demonstration clients include the following:

- Expanded outreach activities and expedited substance abuse assessment using a mobile assessment worker.
- Added treatment options of short-term residential treatment and specialized medical stabilization, detoxification, and treatment slots.
- Expanded case management, maternity support services, and therapeutic child care.

Status: The project received waiver July 1, 1993, through June 30, 1996, and began enrolling eligible substance abusing pregnant women and providing services on July 1, 1993. Approximately 800 women and their children were expected to receive demonstration services during the 3-year operational phase. As of September 1995, 649 clients had received services.

93-079 Demonstration Project for Preventive and Primary Pediatric Care: Maryland

Project No.:	11-W-00003/3
Period:	October 1993–September 1998
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Joseph M. Millstone
Awardee:	Maryland Department of Health and Mental Hygiene 201 West Preston Street Baltimore, MD 21201
HCFA Project Officer:	Sherrie L. Fried Office of State Health Reform Demonstrations

Description: Waivers have been approved for a 5-year period, beginning October 1, 1993, to cover children under Medicaid who meet the following criteria: born after September 30, 1993; between 1 and 19 years of age; not currently eligible for the Medicaid program; and living in families whose income does not exceed 185 percent of the Federal poverty level, with no resource limitation. Maryland intends to demonstrate that access to basic primary care and preventive services increases the utilization of such services, improves health outcomes, and is cost-effective by preventing acute and chronic medical conditions. No hospital inpatient, outpatient, or emergency room coverage will be provided under the demonstration.

Status: Enrollment has been lower than anticipated, despite extensive outreach efforts. Currently, there are 3,547 children enrolled. The State is working on various strategies to increase enrollment. The project recently awarded a radio outreach contract to a local advertising agency to develop radio spots and ensure that these are run on stations throughout Maryland. The spots will target children and pregnant women in need of health care services.

94-063 Effects of Telemedicine on Accessibility, Quality, and Cost of Health Care

Project No.:	18-C-90332/5
Period:	July 1994–July 1997
Funding:	$ 644,086
Award:	Cooperative Agreement
Principal Investigator:	F. W. Womack
Awardee:	University of Michigan 3003 South State Street Ann Arbor, MI 48109-1274
HCFA Project Officer:	Lawrence E. Kucken Division of Health Information and Outcomes

Description: This project is evaluating the effect of telemedicine systems on accessibility, quality, and cost of health care. A detailed methodology for evaluating telemedicine is being developed by a panel of experts and implemented in existing telemedicine programs at the Medical College of Georgia (MCG) Telemedicine Center and Mountaineer Doctor Television (MDTV) at the Health Sciences Center, West Virginia University (WVU). Included in the evaluation design are a quasi-experimental survey study of clients and providers in selected experimental and control communities and a case control study to compare the content, process, and outcomes of episodes of care with and without telemedicine. The project plan has three goals: (1) development of a detailed methodology for a comprehensive evaluation of the effects of telemedicine on accessibility, utilization, quality, and cost of health care, using a panel of experts on quality, economics, clinical medicine, and technology; (2) implementation and testing of the evaluation design at the MCG Telemedicine Center; and (3) extending the evaluation design to MDTV at WVU. The general hypothesis guiding this research is that telemedicine will improve accessibility to health care, enhance the quality of care delivered, and contain costs.

Status: Data collection instruments for this project are in the final stages of development. Full implementation of data collection awaits Medicare demonstration waiver authority for providers to bill for medical services delivered to Medicare beneficiaries.

91-089 Essential Access Community Hospital/ Rural Primary Care Hospital Program: California

Project No.:	60-P-07011/9
Period:	September 1991–September 1996
Funding:	$ 1,798,602
Award:	Grant
Principal Investigator:	Ernesto Iglesias
Awardee:	Office of Statewide Health Planning and Development Primary Care Resources and Community Development Division 1600 9th Street, Room 440 Sacramento, CA 95814
HCFA Project Officer:	Sheldon D. Weisgrau Division of Delivery Systems and Financing
Mandate:	Section 1820 of the Social Security Act (Public Law 101-239)

Description: The Essential Access Community Hospital/ Rural Primary Care Hospital (EACH/RPCH) program is designed to assist States in maintaining access to health care services in rural areas through the development of rural health plans, establishment of rural health networks, and creation of a limited service alternative for communities that can no longer support a full-service hospital. The EACH/ RPCH program consists of a permanent operating program that establishes the EACH as a new hospital category and the RPCH as a new type of health care facility that provides emergency, outpatient, and limited inpatient services and a grant program to provide funds to States and hospitals to assist in the development and implementation of the program. EACHs, RPCHs, and other health care providers are organized into rural health networks that maintain agreements for such services as the transfer and referral of patients, the provision of transportation services, and the development and use of communications systems. The statute limits the program to seven States. Through a competitive process, the Health Care Financing Administration (HCFA) selected California, Colorado, Kansas, New York, North Carolina, South Dakota, and West Virginia to participate. Through fiscal year 1995, HCFA has awarded a total of $23.7 million in grant funds to these States and 96 hospitals in these States for program planning and participation.

Status: The State of California is 1 of 7 States participating in the EACH/RPCH program. Since 1991, the California Office of Statewide Health Planning and Development has received $714,102 in grant funding for program planning, development, and implementation. Grants totaling $1,084,500 have also been awarded to 7 California hospitals in 3 rural health networks.

91-090 Essential Access Community Hospital/ Rural Primary Care Hospital Program: Colorado

Project No.:	60-P-07006/8
Period:	September 1991–September 1996
Funding:	$ 4,523,039
Award:	Grant
Principal Investigator:	Louise Singleton
Awardee:	Colorado Department of Public Health and Environment Rural and Primary Health Policy and Planning 4300 Cherry Creek Drive, South Denver, CO 80222-1530
HCFA Project Officer:	Sheldon D. Weisgrau Division of Delivery Systems and Financing
Mandate:	Section 1820 of the Social Security Act (Public Law 101-239)

Description: The Essential Access Community Hospital/ Rural Primary Care Hospital (EACH/RPCH) program is designed to assist States in maintaining access to health care services in rural areas through the development of rural health plans, establishment of rural health networks, and creation of a limited service alternative for communities that can no longer support a full-service hospital. The EACH/ RPCH program consists of a permanent operating program that establishes the EACH as a new hospital category and the RPCH as a new type of health care facility that provides emergency, outpatient, and limited inpatient services, and a grant program to provide funds to States and hospitals to assist in the development and implementation of the program. EACHs, RPCHs, and other health care providers are organized into rural health networks that maintain agreements for such services as the transfer and referral of patients, the provision of transportation services, and the development and use of communications systems. The statute limits the program to seven States. Through a competitive process, the Health Care Financing Administration (HCFA) selected California, Colorado, Kansas, New York, North Carolina, South Dakota, and West Virginia to participate. Through fiscal year 1995, HCFA has awarded a total of $23.7 million in grant funds to these States and 96 hospitals in these States for program planning and participation.

Status: The State of Colorado is 1 of 7 States participating in the EACH/RPCH program. Since 1991, the Colorado Office of Rural and Primary Health Policy and Planning has received $1,459,904 in grant funding for program planning, development, and implementation. Grants totaling $3,074,135 have also been awarded to 16 Colorado hospitals in 9 rural health networks.

91-091 Essential Access Community Hospital/ Rural Primary Care Hospital Program: Kansas

Project No.:	60-P-07017/7
Period:	September 1991–September 1996
Funding:	$ 5,799,223
Award:	Grant
Principal Investigator:	Richard J. Morrissey
Awardee:	Kansas Department of Health and Environment Bureau of Local and Rural Health Systems 900 SW. Jackson, Room 665 Topeka, KS 66612-1290
HCFA Project Officer:	Sheldon D. Weisgrau Division of Delivery Systems and Financing
Mandate:	Section 1820 of the Social Security Act (Public Law 101-239)

Description: The Essential Access Community Hospital/ Rural Primary Care Hospital (EACH/RPCH) program is designed to assist States in maintaining access to health care services in rural areas through the development of rural health plans, establishment of rural health networks, and creation of a limited service alternative for communities that can no longer support a full-service hospital. The EACH/ RPCH program consists of a permanent operating program that establishes the EACH as a new hospital category and the RPCH as a new type of health care facility that provides emergency, outpatient, and limited inpatient services and a grant program to provide funds to States and hospitals to assist in the development and implementation of the program. EACHs, RPCHs, and other health care providers are organized into rural health networks that maintain agreements for such services as the transfer and referral of patients, the provision of transportation services, and the development and use of communications systems. The statute limits the program to seven States. Through a competitive process, the Health Care Financing Administration (HCFA) selected California, Colorado, Kansas, New York, North Carolina, South Dakota, and West Virginia to participate. Through fiscal year 1995, HCFA has awarded a total of $23.7 million in grant funds to these States and 96 hospitals these States for program planning and participation.

Status: The State of Kansas is 1 of 7 States participating in the EACH/RPCH program. Since 1991, the Kansas Bureau of Local and Rural Health Systems has received $979,702 in grant funding for program planning, development, and implementation. Grants totaling $4,819,521 have also been awarded to 29 Kansas hospitals in 9 rural health networks. As of September 1995, 7 RPCHs in 5 rural health networks in Kansas have been certified to participate in the Medicare program.

91-092 Essential Access Community Hospital/ Rural Primary Care Hospital Program: New York

Project No.:	60-P-07015/2
Period:	September 1991–September 1996
Funding:	$ 2,272,432
Award:	Grant
Principal Investigator:	Paul G. FitzPatrick
Awardee:	New York State Department of Health Office of Rural Health Corning Tower, Room 1656 Empire State Plaza Albany, NY 12237
HCFA Project Officer:	Sheldon D. Weisgrau Division of Delivery Systems and Financing
Mandate:	Section 1820 of the Social Security Act (Public Law 101-239)

Description: The Essential Access Community Hospital/ Rural Primary Care Hospital (EACH/RPCH) program is designed to assist States in maintaining access to health care services in rural areas through the development of rural health plans, establishment of rural health networks, and creation of a limited service alternative for communities that can no longer support a full-service hospital. The EACH/ RPCH program consists of a permanent operating program that establishes the EACH as a new hospital category and the RPCH as a new type of health care facility that provides emergency, outpatient, and limited inpatient services. and a grant program to provide funds to States and hospitals to assist in the development and implementation of the program. EACHs, RPCHs, and other health care providers are organized into rural health networks that maintain agreements for such services as the transfer and referral of patients, the provision of transportation services, and the development and use of communications systems. The statute limits the program to seven States. Through a competitive process, the Health Care Financing Administration (HCFA) selected California, Colorado, Kansas, New York, North Carolina, South Dakota, and West Virginia to participate. Through fiscal year 1995, HCFA has awarded a total of $23.7 million in grant funds to these States and 96 hospitals these States for program planning and participation.

Status: The State of New York is 1 of 7 States participating in the EACH/RPCH program. Since 1991, the New York State Office of Rural Health has received $1,225,432 in grant funding for program planning, development, and implementation. Grants totaling $1,047,002 have also been awarded to 6 New York hospitals in 3 rural health networks. As of September 1995, 1 RPCH had been certified to participate in the Medicare program in New York.

91-093 Essential Access Community Hospital/ Rural Primary Care Hospital Program: North Carolina

Project No.:	60-P-07012/4
Period:	September 1991–September 1996
Funding:	$ 4,135,369
Award:	Grant
Principal Investigator:	James D. Bernstein
Awardee:	North Carolina Department of Human Resources Office of Rural Health and Resource Development 311 Ashe Avenue Raleigh, NC 27606
HCFA Project Officer:	Sheldon D. Weisgrau Division of Delivery Systems and Financing
Mandate:	Section 1820 of the Social Security Act (Public Law 101-239)

Description: The Essential Access Community Hospital/ Rural Primary Care Hospital (EACH/RPCH) program is designed to assist States in maintaining access to health care services in rural areas through the development of rural health plans, establishment of rural health networks, and creation of a limited service alternative for communities that can no longer support a full-service hospital. The EACH/ RPCH program consists of a permanent operating program that establishes the EACH as a new hospital category and the RPCH as a new type of health care facility that provides emergency, outpatient, and limited inpatient services, and a grant program to provide funds to States and hospitals to assist in the development and implementation of the program. EACHs, RPCHs, and other health care providers are organized into rural health networks that maintain agreements for such services as the transfer and referral of patients, the provision of transportation services, and the development and use of communications systems. The statute limits the program to seven States. Through a competitive process, the Health Care Financing Administration (HCFA) selected California, Colorado, Kansas, New York, North Carolina, South Dakota, and West Virginia to participate. Through fiscal year 1995, HCFA has awarded a total of $23.7 million in grant funds to these States and 96 hospitals these States for program planning and participation.

Status: The State of North Carolina is 1 of 7 States participating in the EACH/RPCH program. Since 1991, the North Carolina Office of Rural Health and Resource Development has received $1,379,369 in grant funding for program planning, development, and implementation. Grants totaling $2,756,000 have also been awarded to 14 North Carolina hospitals in 7 rural health networks. As of September 1995, 3 RPCHs in 3 rural health networks have been certified to participate in the Medicare program in North Carolina.

91-094 Essential Access Community Hospital/ Rural Primary Care Hospital Program: South Dakota

Project No.:	60-P-07023/8
Period:	September 1991–September 1996
Funding:	$ 2,414,475
Award:	Grant
Principal Investigator:	Doug Knutson
Awardee:	South Dakota Department of Health Office of Rural Health 445 East Capitol Avenue Pierre, SD 57501-3185
HCFA Project Officer:	Sheldon D. Weisgrau Division of Delivery Systems and Financing
Mandate:	Section 1820 of the Social Security Act (Public Law 101-239)

Description: The Essential Access Community Hospital/ Rural Primary Care Hospital (EACH/RPCH) program is designed to assist States in maintaining access to health care services in rural areas through the development of rural health plans, establishment of rural health networks, and creation of a limited service alternative for communities that can no longer support a full-service hospital. The EACH/ RPCH program consists of a permanent operating program that establishes the EACH as a new hospital category and the RPCH as a new type of health care facility that provides emergency, outpatient, and limited inpatient services, and a grant program to provide funds to States and hospitals to assist in the development and implementation of the program. EACHs, RPCHs, and other health care providers are organized into rural health networks that maintain agreements for such services as the transfer and referral of patients, the provision of transportation services, and the development and use of communications systems. The statute limits the program to seven States. Through a competitive process, the Health Care Financing Administration (HCFA) selected California, Colorado, Kansas, New York, North Carolina, South Dakota, and West Virginia to participate. Through fiscal year 1995, HCFA has awarded a total of $23.7 million in grant funds to these States and 96 hospitals in these States for program planning and participation.

Status: The State of South Dakota is 1 of 7 States participating in the EACH/RPCH program. Since 1991, the South Dakota Office of Rural Health has received $741,782 in grant funding for program planning, development, and implementation. Grants totaling $1,672,693 have also been awarded to 12 South Dakota hospitals in 6 rural health networks. As of September 1995, 5 RPCHs in 4 rural health networks have been certified to participate in the Medicare program in South Dakota.

91-095 Essential Access Community Hospital/ Rural Primary Care Hospital Program: West Virginia

Project No.:	60-P-07008/3
Period:	September 1991–September 1996
Funding:	$ 2,735,096
Award:	Grant
Principal Investigator:	Sandra Pope
Awardee:	West Virginia Department of Health and Human Resources Bureau for Public Health Office of Rural Health Policy 1411 Virginia Street, East Charleston, WV 25301
HCFA Project Officer:	Sheldon D. Weisgrau Division of Delivery Systems and Financing
Mandate:	Section 1820 of the Social Security Act (Public Law 101-239)

Description: The Essential Access Community Hospital/ Rural Primary Care Hospital (EACH/RPCH) program is designed to assist States in maintaining access to health care services in rural areas through the development of rural health plans, establishment of rural health networks, and creation of a limited service alternative for communities that can no longer support a full-service hospital. The EACH/ RPCH program consists of a permanent operating program that establishes the EACH as a new hospital category and the RPCH as a new type of health care facility that provides emergency, outpatient, and limited inpatient services, and a grant program to provide funds to States, and hospitals to assist in the development and implementation of the program. EACHs, RPCHs, and other health care providers are organized into rural health networks that maintain agreements for such services as the transfer and referral of patients, the provision of transportation services, and the development and use of communications systems. The statute limits the program to seven States. Through a competitive process, the Health Care Financing Administration (HCFA) selected California, Colorado, Kansas, New York, North Carolina, South Dakota, and West Virginia to participate. Through fiscal year 1995, HCFA has awarded a total of $23.7 million in grant funds to these States and 96 hospitals in these States for program planning and participation.

Status: The State of West Virginia is 1 of 7 States participating in the EACH/RPCH program. Since 1991, the West Virginia Office of Community and Rural Health Services has received $1,058,330 in grant funding for program planning, development, and implementation. Grants totaling $1,676,766 have also been awarded to 12 West Virginia hospitals in 6 rural health networks. As of September 1995, 2 RPCHs in 2 rural health networks have been certified to participate in the Medicare program in West Virginia.

93-074 Evaluation of Clinical and Educational Services to Rural Hospitals via Fiber-Optic Cable

Project No.:	18-C-90254/7
Period:	September 1993–January 1996
Funding:	$ 698,322
Award:	Cooperative Agreement
Principal Investigator:	David S. Ramsey
Awardee:	Iowa Methodist Health System 1200 Pleasant Street Des Moines, IA 50309
HCFA Project Officer:	Lawrence E. Kucken Division of Health Information and Outcomes

Description: This project is providing the Health Care Financing Administration with an evaluation of the effectiveness of a telemedicine system linking hospitals to an existing statewide fiber-optic communications network. The Iowa Methodist Medical Center has been linked to both Greene County Medical Center and Trinity Regional Hospital. Project services include telemedicine (e.g., radiology, cardiology, pathology consultations), education, and information systems components. Because of the limited sample size, the evaluation is focused on input and process indicators, as opposed to outcome indicators.

Status: The first telemedicine services under the demonstration were provided in April 1994, but full-scale use of the system awaits Medicare demonstration waiver authority for providers to bill for medical services delivered to Medicare beneficiaries.

90-006 Evaluation of the Cost Effectiveness of Medicare Coverage of Influenza Vaccine

Project No.:	500-89-0049
Period:	October 1989–December 1994
Funding:	$ 3,062,471
Award:	Contract
Principal Investigator:	David Kidder, Ph.D.
Awardee:	Abt Associates, Inc. 55 Wheeler Street Cambridge, MA 02138
HCFA Project Officer:	Edward T. Hutton, Ph.D. Office of State Health Reform Demonstrations
Mandate:	Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203)

Description: The objective of this project is to evaluate the cost-effectiveness of furnishing influenza vaccinations to Medicare Part B beneficiaries as a Medicare-covered benefit. The demonstration included intervention and comparison areas in 10 sites and 10 statewide vaccine projects. In the former paired sites, bulk-purchased vaccine was distributed to providers, intensive beneficiary and provider motivation campaigns were undertaken, private providers were paid $8 per dose to administer the vaccine (clinics were paid $4), and a dedicated carrier processed the claims. In the statewide sites, an influenza vaccination was treated as a covered benefit, and the local carrier paid providers for the cost of the vaccine and its administration. For the evaluation, the contractor is measuring the cost of the immunization benefit relative to the reduction in pneumonia and influenza hospitalization admissions (attributable to vaccine use) during the influenza season. The vaccine's effectiveness in preventing pneumonia and influenza hospital admissions was estimated through case control studies included in the demonstration. A national panel of experts assisted the Health Care Financing Administration, the Centers for Disease Control and Prevention, and the contractor in conducting the demonstration and evaluation.

Status: Effective May 1, 1993, following the Report to Congress on April 26, 1993 from Secretary Shalala, Medicare began paying for influenza vaccinations. As permitted by Congress through section 4071 of Public Law 100-203, this service adds to the package of prevention services that Medicare already covers, which includes hepatitis B vaccines, pneumococcal pneumonia vaccines, mammograms, and Pap smears. Measures of vaccine effectiveness during the defined influenza circulation period of severe influenza season were estimated to range from 32 to 45 percent. This range, which includes estimates from 2 severe seasons and 4 studies, may be viewed as low because of possible misclassification of cases since a confirmatory lab test for a preceding influenza illness was not possible. Overall survey vaccination rates for the fourth year of the demonstration (1991-92) were determined to be 59 and 46 percent, respectively, in the intervention and comparison areas. Influenza vaccination levels in 4 of 10 intervention sites exceeded the national health objective for the year 2000 of 60 percent vaccine coverage among noninstitutionalized persons 65 years and over, and overall vaccination levels in the demonstration (59 percent) nearly reached this objective. Taking into account the 2-point differential in vaccination rates in intervention and comparison areas that was observed at baseline, the demonstration is inferred to have increased vaccine coverage by 11 points. Vaccine coverage was increased through a variety of activities to promote and distribute vaccines to Medicare beneficiaries. These activities included Medicare paying for the administration and bulk purchase of the vaccine, sending informational letters to beneficiaries living in the demonstration areas, and using motivational techniques to make influenza vaccination a routine practice in provider offices. The contractor completed a national and demonstration followup survey of vaccine coverage during the 1993-94 influenza season among Medicare beneficiaries, which found that the national rate of influenza vaccine coverage was 58 percent of Medicare eligibles and 28 percent for pneumococcal vaccine. Published reports from the Medicare Influenza Vaccine Demonstration include the following:

- Hannoun, C., Ruben, F., Klenk, H., et al., Eds: "Options for the Control of Influenza II: Proceedings of the International Conference on Options for the Control of Influenza, Courchevel, 27 September–2 October, 1992." Elsevier Science Publishers B.V., Amsterdam, p. 468, 1993.
- Centers for Disease Control: "26th National Immunization Conference Proceedings." Atlanta, p. 214, 1993.
- Centers for Disease Control: "27th National Immunization Conference Proceedings." Atlanta, p. 214, in press.
- Centers for Disease Control: "Final Results: Medicare Influenza Vaccine Demonstration—Selected States, 1988–1992." *MMWR* 42(31):601-604, 1993.

91-078 Evaluation of the Essential Access Community Hospital/Rural Primary Care Hospital Program

Project No.:	500-87-0028
Period:	September 1991–January 1995
Funding:	$ 718,109
Award:	Technical Support: Evaluation of Demonstrations Mathematica Policy Research, Inc. 600 Maryland Avenue, SW., Suite 550 Washington, DC 20024-2512

Principal Investigator: George E. Wright, Ph.D.
Awardee: Mathematica Policy Research, Inc.
P.O. Box 2393
Princeton, NJ 08543-2393
HCFA Project Officer: Sheldon D. Weisgrau
Division of Delivery Systems and Financing

Mandate: Section 1820 of the Social Security Act (Public Law 101-239)

Description: The Essential Access Community Hospital/ Rural Primary Care Hospital (EACH/RPCH) program is designed to assist States in maintaining access to health care services in rural areas through the development of rural health plans, establishment of rural health networks, and creation of a limited service alternative for communities that can no longer support a full-service hospital. The EACH/ RPCH program consists of a permanent operating program that establishes the EACH as a new hospital category and the RPCH as a new type of health care facility that provides emergency, outpatient, and limited inpatient services, and a grant program to provide funds to States and hospitals to assist in the development and implementation of the program. EACHs, RPCHs, and other health care providers are organized into rural health networks that maintain agreements for such services as the transfer and referral of patients, the provision of transportation services, and the development and use of communications systems. Seven States—California, Colorado, Kansas, New York, North Carolina, South Dakota, and West Virginia—participate in the program.

The Health Care Financing Administration contracted with Mathematica Policy Research (MPR) to conduct an evaluation of the development, implementation, and early operating experience of the EACH/RPCH program. This project also includes an analysis of the Montana Medical Assistance Facility Demonstration, a forerunner of the EACH/RPCH program.

Status: A final report on this project was completed by MPR in 1995. Evaluation findings indicate that limited service hospital models occupy a niche in rural health care systems—they fill a needed role by offering some hospitals an alternative to closure, but there are also considerable limitations to participation. The financial benefits of participation in a limited service hospital program, such as EACH/RPCH, vary by facility, depending on such factors as cost structure, provider supply, and use patterns in the community. The study indicates that program flexibility is needed to address local issues and that linkage of primary care services to developing networks is essential. The evaluators caution, however, that these findings are based on limited data and that additional program operating experience is necessary to draw firm conclusions on the impact of the program.

93-002 Expanded Cross-Cutting Evaluation of Medicare Prevention Demonstrations Under the Consolidated Omnibus Budget Reconciliation Act

Project No.: 500-92-0057
Period: October 1992–March 1995
Funding: $ 357,699
Award: Contract
Principal Investigator: David Kidder, Ph.D.
Awardee: Abt Associates, Inc.
55 Wheeler Street
Cambridge, MA 02138-1168
HCFA Project Officer: Deborah C. Van Hoven
Office of State Health Reform Demonstrations

Mandates: Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272)
Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: Abt Associates, Inc., conducted a cross-cutting evaluation of the five Medicare prevention demonstrations, mandated by the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, which tested the effectiveness of providing disease prevention and health promotion services to Medicare beneficiaries. Congress stipulated that the preventive health service package to be made available was to include health screenings, health risk appraisals, immunizations, and counseling and instruction in diet and nutrition, stress reduction, exercise programs, sleep regulation, injury prevention, substance abuse and mental disorders prevention, self-care (including medication use), and smoking cessation.

Status: The contract for a cross-cutting evaluation was initially awarded September 30, 1987, and in May 1988, cooperative agreements were awarded to five schools of public health to implement the demonstration. Waivered services were provided between May 1989 and April 1991. A preliminary Report to Congress (RTC) was submitted in July 1989. The COBRA 1985 legislation mandated 4-year demonstrations; the Omnibus Budget Reconciliation Act (OBRA) of 1990 extended them to 5 years. The OBRA 1990 extension allowed for an additional year of followup for purposes of evaluation and added an interim RTC, which was submitted to Congress in September 1993, and a final RTC, which is to include a comprehensive evaluation of the long-term effects of the demonstration. The original evaluation contract was modified in October 1992 as a result of the OBRA 1990 extension. The final RTC is expected to be submitted to Congress in early 1996.

95-056 International Comparative Data and Analysis of Health Care Financing and Delivery Systems

Project No.:	500-95-0001
Period:	August 1995–August 2000
Funding:	$ 1,455,100
Award:	Sole Source Contract
Principal Investigator:	Jean Pierre Poullier
Awardee:	Organization for Economic Cooperation and Development (OECD) 2 Rue Andre Pascal 75775 Paris Cedex 16 FRANCE
HCFA Project Officer:	Leslie M. Greenwald, Ph.D. Division of Delivery Systems and Financing

Description: The Organization for Economic Cooperation and Development (OECD) has developed a unique database that contains information on healthcare financing and use in industrialized Western Nations. The OECD will collect data on the following member countries: Australia, Austria, Belgium, Canada, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Japan, Luxembourg, the Netherlands, New Zealand, Norway, Portugal, Spain, Sweden, Switzerland, Turkey, the United Kingdom, and the United States. This project obtains these data on an ongoing basis and updates and expands them, along with a series of papers analyzing the trends in Western developed nations and their policy relevance to the United States.

Status: The contract was awarded in August 1995 and is in its first year.

95-023 Maximizing the Effective Use of Telemedicine: A Study of the Effects, Cost Effectiveness, and Utilization Patterns of Consultation via Telemedicine

Project No.:	18-C-90617/8
Period:	September 1995–September 1998
Funding:	$ 524,188
Award:	Cooperative Agreement
Principal Investigators:	Jim Grigsby, Ph.D., and Robert E. Schlenker, Ph.D.
Awardee:	Center for Health Policy Research University of Colorado Denver, CO 80202
HCFA Project Officer:	William L. England, Ph.D., J.D. Division of Health Information and Outcomes

Description: The objective of this project is to design and conduct a comprehensive evaluation of the Health Care Financing Administration's (HCFA's) telemedicine research demonstration projects. The awardee, in consultation with the individual demonstration sites, will formulate a cross-cutting evaluation design, including data collection and analysis, to assess alternative payment options for the providers of telemedicine services, such as fee-for-service, facility payments, or capitation. The awardee will devise objective measures of the cost of telemedicine services in different clinical settings, both from the payer's and the physician's perspective, and will develop an evaluation strategy by which alternative payment options for telemedicine services can be assessed. The awardee also will examine provider and patient satisfaction, utilization measures such as physician visits, hospitalizations, or rehospitalization, frequencies of complications or comorbidities, and the effect of telemedicine on practice patterns. HCFA hopes to use the information gained from this project to develop a cost-effective payment strategy for telemedicine services in Medicare.

Status: This project was just awarded and is in the early development stage.

95-050 Medicare Negotiated Bundled Payment Demonstrations: Design and Solicitation

Project No.:	500-92-0013TO04
Period:	July 1995-June 1996
Funding:	$ 207,920
Award:	Technical Support: Design and Solicitation
Principal Investigator:	Jerry Cromwell, Ph.D.
Awardee:	Health Economics Research, Inc. (See page 203)
HCFA Project Officer:	Armen H. Thoumaian Division of Delivery Systems and Financing

Description: The awardee will assist the Health Care Financing Administration (HCFA) in preparing the design and solicitation of a 3-year demonstration to test the feasibility of a negotiated all-inclusive pricing arrangement for a group of cardiovascular procedures and total joint replacement procedures at high-volume hospitals in targeted geographic areas. The awardee will assist HCFA in the formulation of the design, identification of factors for the selection of demonstration sites, development and publication of a solicitation package, and the analysis and review of respondent proposals.

Status: The geographic analysis was completed with recommendations for specific metropolitan statistical areas and multistate regions in which to target the demonstration solicitation. Preliminary drafts of the design and solicitation

documentation have been submitted for an expected mailing of a preapplication solicitation in December 1995. Preapplicants recommended by a review panel will be invited to submit final applications. Panel review of final applications should be completed by May 1996.

94-066 Midwest Rural Telemedicine Consortium: A Pilot Demonstration Project

Project No.:	95-C-90425/7
Period:	July 1994–July 1997
Funding:	$ 1,777,831
Award:	Cooperative Agreement
Principal Investigator:	John A. Kolosky
Awardee:	Mercy Foundation Sixth and University Des Moines, IA 50314
HCFA Project Officer:	Lawrence E. Kucken Division of Health Information and Outcomes

Description: This project is evaluating the medical effectiveness, patient and provider acceptance, and costs associated with telemedicine services, as well as their impact on access to care in rural areas. The demonstration involves six rural hospitals (Audubon County Memorial Hospital, Franklin General Hospital, Hamilton County Public Hospital, Kossuth County Hospital, St. Joseph Community Hospital, and St. Joseph's Mercy Hospital); one rural referral hospital (North Iowa Mercy Health Center); and one urban hospital (Mercy Hospital Medical Center). Planned services for the demonstration include interactive video consults for teleradiology, telepathology, and, where available, telesonography, electrocardiography, and fetal monitoring strips. Payment for related physician services is expected to be made under a waiver of Medicare payment regulations. The goal of the project is to evaluate whether specialty telemedicine services provided by hospital networks produce change with respect to medical effectiveness, patient and provider satisfaction, cost, and access. Hypotheses include telemedicine improving differential diagnoses and treatment; patients and providers being as satisfied with telemedicine as with on-site services; telemedicine services being less costly than on-site services; and telemedicine improving access to a wider range of health care services.

Status: This telemedicine network is nearing completion. Full-scale use of the system awaits Medicare demonstration waiver authority for providers to bill for medical services delivered to Medicare beneficiaries.

94-064 Rural Telemedicine Demonstration Grant

Project No.:	95-C-90367/4
Period:	July 1994–July 1997
Funding:	$ 271,514
Award:	Cooperative Agreement
Principal Investigator:	Diane M. Jacobs
Awardee:	East Carolina University Greenville, NC 27858
HCFA Project Officer:	William L. England, Ph.D., J.D. Division of Health Information and Outcomes

Description: This project is collecting case studies and hard data describing the impact and quality of medical care in remote areas. Other items being studied include use rates and cost structure, types of services appropriate to telemedicine, diagnostic effectiveness, and payment methodology. The demonstration will test a system of Medicare payments for telemedicine services involving two rural North Carolina hospitals, Roanoke-Chowan Hospital and Martin General Hospital, interacting with the regional medical center and medical school affiliate, Pitt County Memorial Hospital, to deliver primary care services. The project has eight objectives: (1) to evaluate the impact of telemedicine on access to care; (2) to determine specialty services appropriate for rural telemedicine; (3) to determine whether the type of health care provider presenting the patient to the consultant affects the quality and clinical value of the consultation; (4) to evaluate the educational value of the telemedicine consultation; (5) to develop a prototype for delivery of telemedicine services; (6) to determine if the diagnostic effectiveness for dermatological examinations can be maintained via telecommunications; (7) to evaluate the costs of providing telemedicine services (direct, indirect, and ancillary); (8) and to examine the impact of payment for telemedicine services on the actual consultation and on the broader health care delivery system.

Status: This project is still being developed. Full-scale use of the system awaits Medicare demonstration waiver authority for providers to bill for medical services delivered to Medicare beneficiaries.

94-123 State-Administered Programs for Human Immunodeficiency Virus-Related Care

Project No.:	18-P-90286/5
Period:	September 1994–August 1996
Funding:	$ 56,133
Award:	Grant
Principal Investigator:	Robert J. Buchanan, Ph.D.
Awardee:	Board of Trustees of the University of Illinois Department of Community Health 109 Coble Hall 801 South Wright Street Champaign, IL 61820
HCFA Project Officer:	Michael Kendix, Ph.D. Division of Health Information and Outcomes

Description: The study describes, catalogues, and analyzes a range of State-administered public programs that cover and finance the health care needs of persons with acquired immunodeficiency syndrome (AIDS) and persons who are infected with the human immunodeficiency virus (HIV). The study focuses on Title II programs of the Ryan White CARE Act; State-funded, medical assistance programs; and Medicaid 2176 home and community-based waivers. It also focuses on the action of the States' health departments that address the increasing incidence of tuberculosis, especially among persons with AIDS and people who are HIV positive, and the coordination of eligibility for these State-administered programs with the Medicaid program of each State. This project also investigates the assessments the administrators of each State's AIDS office (as well as the administrators of voluntary AIDS organizations at the state and local levels) have about how well each of these State-administered programs (including Medicaid) addresses the health care needs of people with AIDS and people infected with HIV, closing any holes in the Medicaid safety net.

Status: This project has almost completed the data collection phase and is focusing on reporting the initial findings of its survey.

94-129 Sustainable Support System for Telemedicine Research and Evaluation

Project No.:	18-C-90413/0
Period:	September 1994–March 1996
Funding:	$ 246,296
Award:	Cooperative Agreement
Principal Investigator:	Douglas A. Perednia, M.D.
Awardee:	Telemedicine Research Center 7276 Southwest Beaverton-Hillsdale Highway, Suite 187 Portland, OR 97225
HCFA Project Officer:	William L. England, Ph.D., J.D. Division of Health Information and Outcomes

Description: The goal of this project is to create an effective, ongoing mechanism by which the cost, effectiveness, and utility of telemedicine services can be systematically evaluated. This is being done through formation of a Clinical Telemedicine Cooperative Group (CTCG). The CTCG is based at the Telemedicine Research Center, a nonprofit public service research corporation in Portland, Oregon, that has been formed to foster high-quality research in telemedicine. The CTCG is modeled after a successful cooperative multicentered research organization. Functions of the CTCG include:
(1) providing operational and statistical support for telemedicine research and evaluation; (2) maintaining a communication system to link geographically distant telemedicine projects to share information and perform telemedicine research; (3) creating easily adaptable, electronic data collection and tabulation instruments for use in telemedicine research; and (4) building a comprehensive on-line telemedicine information clearinghouse for gathering, storing, and disseminating information about the utility, effectiveness, and suitability of telemedicine for a broad range of medical and social applications.

Status: This project is in the early development stage. Data collection instruments are in the final stages of development for the Mercy Foundation and the Iowa Methodist Health System in Des Moines, Iowa, as well as for East Carolina University in Greenville, North Carolina.

93-026 Virtual Interactive Rehabilitation via Remote Computer

Project Nos.:	97-P-08040/0-01 (Phase I) 97-P-08040/0-02 (Phase II)
Period:	February 1993–January 1994 (Phase I) February 1994–January 1995 (Phase II)
Funding:	$ 34,930 (Phase I) $ 117,958 (Phase II)
Award:	Grant
Principal Investigator:	Howard Davis, Ph.D.
Awardee:	ScienTech, Inc. SE. 1122 Latah Street Pullman, WA 99163

HCFA Project Officer: Carl S. Hackerman
Financial, Administrative, and Procurement Staff

Mandate: Small Business Innovation Development Act of 1982 (Public Law 97-219; as amended by the Small Business Innovation Research Program, Extension, Public Law 99-443)

Description: The primary objective of this project is to test the feasibility of linking physical rehabilitation patients to remote caregivers by means of a novel high-performance data analysis and communications system. The system involves computer-driven rehabilitation equipment and advanced telecommunications designed to bring the therapist into the home.

Status: This project is in Phase II (testing and data gathering). Because the Small Business Innovation Research program sponsors the development of commercially viable products, it carefully protects the developer's intellectual property. Any detailed information on this project and the product must be obtained from the awardee.

Subacute and Long-Term Care

94-086 Acute and Long-Term Care: Use, Costs, and Consequences

Project No.:	17-C-90323/3
Period:	September 1994–August 1997
Funding:	$595,787
Award:	Cooperative Agreement
Principal Investigator:	Korbin Liu, Ph.D.
Awardee:	The Urban Institute 2100 M Street, NW. Washington, DC 20037
HCFA Project Officer:	Carolyn Rimes Division of Aging and Disability

Description: This study will provide current information that will aid policymakers in developing options to better integrate acute, subacute, and long-term care services. Data from the Medicare Current Beneficiary Survey will be used to address three issues: transitions among acute, subacute, and long-term care; catastrophic costs resulting from the use of those services; and interactions between Medicare and Medicaid home health care. The transitions analysis is designed to measure differences in the patterns of acute, subacute, and long-term care use by the characteristics of Medicare beneficiaries, and to determine potential areas of access or quality of care problems. The cost analysis is designed to assess the cumulative risks over 3 years of incurring catastrophic health care costs or experiencing Medicaid spenddown. The effects of the Qualified Medicare Beneficiaries program will be evaluated. The home health care analysis is designed to estimate the interactions and possible overlaps between two rapidly expanding public programs that finance similar services. The relationship between home health care use and costs and the personal characteristics of Medicare beneficiaries and the characteristics of geographic areas, including Medicaid policies, will be examined.

Status: This project is in the development phase.

94-047 Analysis of Choice Processes in Capitated Plan Enrollment: Statistical Models for Evaluation of Voluntary Enrollment to Long-Term Care Demonstration Projects

Project No.:	500-89-0047/45
Period:	January 1994–May 1994
Funding:	$217,800
Award:	Contract
Principal Investigator:	David Kennell
Awardee:	Lewin/VHI, Inc. (See page 148)
HCFA Project Officer:	Carolyn Rimes Division of Aging and Disability

Description: The purpose of this study is to update/refine previous work on the factors affecting a person's decision to enroll in managed-care plans. This study comprises five tasks:

Task 1. Evaluate the Health Care Financing Administration cost reports to determine whether conclusions previously made about social health maintenance organization (S/HMO) expenditures, which were obtained using the management information files obtained from each S/HMO site, are affected.
Task 2. Conduct outcome analyses for each of the four sites.
Task 3. Estimate cost regressions using the two-stage regression procedure.
Task 4. Conduct an outcome analysis using Cox regression.
Task 5. Conduct choice modeling.

Status: This project has been completed.

92-093 Analysis of Nonparticipation in the 2176 Program (Formerly, Long-Term Care Studies (Section 207))

Project No.:	500-89-0047/34
Period:	June 1992–November 1994
Funding:	$132,400
Award:	Contract
Principal Investigator:	David Kennell
Awardee:	Lewin/VHI, Inc. (See page 148)
HCFA Project Officer:	Carolyn Rimes Division of Aging and Disability

Description: In recent years, a major focus of research on home and community based care (HCBC) has been on the number of persons who would be eligible for services on dependencies in activities of daily living (ADL). While previous researchers have estimated the size of beneficiary populations under different eligibility standards, little is known about the number of eligibles who would actually

participate in HCBC programs. This project examines why 20 percent of persons meeting ADL requirements for eligibility did not participate in the Medicaid 2176 program in Connecticut. The subsequent use of long-term care services by these nonparticipants is compared to the use of services by participants in the Connecticut Medicaid 2176 program.

Status: This project has been completed. Findings from the study will be published as part of the proceedings from the Brookings Conference.

92-094 **Analysis of Nursing Home Payment with Current Beneficiary Survey Data** (Formerly, Long-Term Care Studies (Section 207))

Project No.:	500-89-0047/32
Period:	May 1992–December 1994
Funding:	$ 55,500
Award:	Contract
Principal Investigator:	David Kennell
Awardee:	Lewin/VHI, Inc. (See page 148)
HCFA Project Officer:	Carolyn Rimes Division of Aging and Disability

Description: Although national estimates of nursing home expenditures have been derived from various databases, direct estimates of the distribution of nursing home patients by the amount of payment and by the source of payment have not been derived. This study is the first attempt to utilize a major source of new information on nursing home payment, the Medicare Current Beneficiary Survey, to estimate these distributions. The Current Beneficiary Survey provides detailed information on payment sources and amounts paid by each source for a nationally representative sample of aged Medicare nursing home patients. This work has been subcontracted to Korbin Liu of the Urban Institute.

Status: There have been delays in the release of the "Medicare Current Beneficiary Survey Public Use Files on Cost and Use." This study is expected to be completed by March 1996.

94-046 **Analysis of Post-Acute Care and Therapy Services Using the Health Care Financing Administration Episode Database**

Project No.:	500-89-0047/46
Period:	August 1994–April 1995
Funding:	$ 138,300
Award:	Contract
Principal Investigator:	David Kennell
Awardee:	Lewin/VHI, Inc. (See page 148)
HCFA Project Officer:	Carolyn Rimes Division of Aging and Disability

Description: This two-part study uses the Health Care Financing Administration Episode Database to do the following:

- Update earlier research on post-hospital care and rehabilitation following hospital admissions with more recent data.
- Examine trends in use over time by comparing the 1992 findings to several RAND analyses and a Lewin/VHI analysis on therapy services conducted for the American Association for Retired Persons.
- Analyze the use of rehabilitation/therapy services across settings.
- Contribute to the discussion of policy and payment implications of increased use of post-acute services.

Status: Tabulations on rehabilitation are under way. A draft report will be submitted in November 1995. The post-acute analysis is expected in April 1996.

92-097 **Analysis of Transitions in the Characteristics of the Long-Term Care Population** (Formerly, Long-Term Care Studies (Section 207))

Project No.:	500-89-0047/11
Period:	December 1991–November 1994
Funding:	$ 63,900
Award:	Contract
Principal Investigator:	David Kennell
Awardee:	Lewin/VHI, Inc. (See page 148)
HCFA Project Officer:	Carolyn Rimes Division of Aging and Disability

Description: This study analyzed home health and skilled nursing facility use for the period 1982-90. Utilizing the 1982, 1984, and 1989 linked National Long-Term Care Survey, this research focuses on the longitudinal changes in health and functioning, institutional risks, and mortality risks for elderly persons with a given impairment level. The combined survey and administrative data analyses were performed to ascertain how the chronic health and functional characteristics of community and institutional residents using Medicare-reimbursed services changed during this period. This article also includes changes that have been made in the Medicare system and traces the impact of these changes on the use of services for persons with specific health and functional problems.

Status: The report is final and was published as an article entitled "Home Health and Skilled Nursing Facility Use: 1982-90" in the *Health Care Financing Review*, Fall 1994, Volume 16, Number 1, pages 155-186.

93-089 **Case Studies of Medicaid Estate Planning** (Formerly, Long-Term Care Studies (Section 207))

Project No.:	500-89-0047/39
Period:	April 1993–December 1994
Funding:	$ 200,000
Award:	Contract
Principal Investigator:	David Kennell
Awardee:	Lewin/VHI, Inc. (See page 148)
HCFA Project Officer:	Carolyn Rimes Division of Aging and Disability

Description: There are two major purposes for these case studies. The first is to provide in-depth descriptive analyses of State policy responses to Medicaid estate planning, including the effectiveness of estate recovery programs. The second is to provide a methodology for conducting quantitative empirical studies that measure the extent of Medicaid estate planning activity and the relative cost-effectiveness of alternative State policy responses. The data used were obtained from Medicaid eligibility offices in Connecticut, Florida, California, and New York. This project was completed by SysteMetrics/MedStat, under subcontract to Lewin/VHI, Inc.

Status: The final analyses have been completed and are currently under review.

93-090 **Catastrophic Costs and Medicaid Spenddown** (Formerly Long-Term Case Studies (Section 207))

Project No.:	500-89-0047/37
Period:	January 1993–May 1995
Funding:	$ 180,300
Award:	Contract
Principal Investigator:	David Kennell
Awardee:	Lewin/VHI, Inc. (See page 148)
HCFA Project Officer:	Carolyn Rimes Division of Aging and Disability

Description: This study uses data from the Medicare Current Beneficiary Survey (MCBS) to analyze the occurrence of catastrophic costs among the elderly resulting from Medicaid spenddown. The purpose of this study is to support the formulation of policy for health care reform for the elderly. Consequently, this study categorizes the causes of out-of-pocket costs for different types of acute and long-term care services that may create financial hardships and identifies which subgroups of the elderly are likely to incur catastrophic costs. This work will be completed by the Urban Institute under subcontract to Lewin/VHI, Inc.

Status: The report, "MCBS 1992 Public Use File for Cost and Use," has been delayed. Preliminary analyses will be completed by February 1996. The final report is expected in May 1996.

92-098 **Catastrophic Costs of Long-Term Care** (Formerly, Long-Term Care Studies (Section 207))

Project No.:	500-89-0047/12
Period:	December 1991–November 1995
Funding:	$ 50,000
Award:	Contract
Principal Investigator:	David Kennell
Awardee:	Lewin/VHI, Inc. (See page 148)
HCFA Project Officer:	Carolyn Rimes Division of Aging and Disability

Description: This study employs the Brookings/ Intermediate Care Facility Long-Term Care Financing Model to examine both current and future financial burdens associated with long-term care costs.

Status: Findings from this study will be published in the conference proceedings from the Brookings Institution.

94-083 **Changing Roles of Nursing Homes**

Project No.:	17-C-90428/5
Period:	September 1994–September 1997
Funding:	$ 831,182
Award:	Cooperative Agreement
Principal Investigator:	Brant Fries, Ph.D.
Awardee:	Institute of Gerontology University of Michigan 300 North Ingalls Building, Room 900 Ann Arbor, MI 48109-2007
HCFA Project Officer:	Ellen O'Brien Division of Aging and Disability

Description: The nursing home industry is one of the most rapidly changing parts of the health care system. Although nursing homes have traditionally provided custodial care to the physically and cognitively impaired elderly, nursing homes are increasingly treating a more diverse patient mix. Since the implementation of Medicare's prospective payment system for hospitals, for example, growing numbers of nursing homes have been getting into the business of caring for persons requiring "subacute" or post-acute care

following a hospital stay. This study examines two special nursing home populations: the chronically mentally ill (beyond those with dementia) and hospice residents. A large sample of resident assessments collected on nursing home residents in several States is to be assembled and linked to such Federal data sets as the Online Survey and Certification Reports, the area resource file, and Medicare Part A and Part B claims files to answer the research questions. The assessment tool, the Minimum Data Set for Nursing Home Resident Assessment and Care Screening, currently is used to collect health status data on all nursing home residents in Medicaid- and Medicare-certified nursing facilities. Several quality, use, and cost issues will be examined. It is hypothesized, for example, that residents with chronic mental illness are more likely than are other similarly impaired residents to be chemically restrained, to experience increasing functional impairment, and to have increased behavior problems. Consequently, it also is hypothesized that the chronically mentally impaired have greater overall use of Medicare services than do non-mentally impaired residents with similar levels of functional impairment. With regard to the population of hospice users, it is hypothesized that these residents should have a lower rate of rehospitalization than do nonhospice nursing home residents with similar medical conditions. The secondary data analysis will permit an analysis of these special populations and will provide policy-relevant information to the Health Care Financing Administration on future directions for nursing homes.

Status: Brown University has developed longitudinal files of MMACS (facility) data from 1991-95 and is merging these data with the resident-level assessment data. These data have been used for an article to appear in *Generations,* reporting the growth of hospice units in nursing homes.

92-070 **Community Nursing Organization Demonstration: Carle Clinic Association** (Formerly, Community Nursing Organization Demonstration)

Project No.:	500-92-0053
Period:	September 1992–December 1996
Funding:	$ 1,786,629
Award:	Contract
Principal Investigator:	Cheryl Schraeder, Ph.D.
Awardee:	Carle Clinic Association 307 East Oak, Suite 3 P.O. Box 718 Mahomet, IL 61853
HCFA Project Officer:	Thomas Theis Division of Aging and Disability
Mandate:	Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203)

Description: Section 4079 of Public Law 100-203 directs the Secretary of the Department of Health and Human Services to conduct demonstration projects at four or more sites to test a capitated, nurse-managed system of care. The two fundamental elements of the Community Nursing Organization (CNO) Demonstration are capitated payment and nurse case management. These two elements are designed to promote timely and appropriate use of community health services and to reduce the use of costly acute care services. The legislation mandates a CNO service package that includes home health care, durable medical equipment, and certain ambulatory care services. Four applicants were awarded site demonstration contracts on September 30, 1992. The selected sites represent a mix of urban and rural sites and different types of health providers, including a home health agency (HHA), a hospital-based system, and a large multispecialty clinic. The four sites are the following:

- Carle Clinic Association, Mahomet, Illinois, one of the largest multispecialty physician group practices in the United States, functions as the regional medical center for the rural population of Central Illinois and Western Indiana and serves nearly 2,000 patients daily.
- Carondelet Health Services, Inc., Tucson, Arizona, a group of three hospitals, a family center, and 17 community health centers, is sponsored by the Sisters of St. Joseph of Carondelet.
- Visiting Nurse Service of New York, New York, is the largest nonprofit Medicare-certified HHA in the United States.
- Living at Home/Block Nurse Program, St. Paul, Minnesota, is a nursing organization dedicated to assisting communities in replicating the Living at Home/ Block Nurse Program model of local volunteer and nursing support for the elderly.

Status: All four CNO Demonstration sites have undergone a 1-year development period and began a 3-year operational period in January 1994, which continued in 1995. Abt Associates, Inc. was selected to evaluate the project and to provide technical assistance to the four CNO sites. Abt Associates, Inc. also was awarded the external quality assurance contract.

92-071 **Community Nursing Organization Demonstration: Carondelet Health Services, Inc.** (Formerly, Community Nursing Organization Demonstration)

Project No.:	500-92-0055
Period:	September 1992–December 1996
Funding:	$ 804,758
Award:	Contract
Principal Investigator:	Gerri Lamb, Ph.D.

Awardee:	Carondelet Health Services, Inc. Carondelet St. Mary's Hospital 1601 West St. Mary's Road Tucson, AZ 85745
HCFA Project Officer:	Thomas Theis Division of Aging and Disability
Mandate:	Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203)

Description: The purpose of the Community Nursing Organization (CNO) demonstration is to develop and evaluate a nurse case-managed health care delivery system that provides Medicare-covered home health services, ambulatory care services, and durable medical equipment to eligible beneficiaries. Section 4079 of Public Law 100-203 directed the Secretary of the Department of Health and Human Services to conduct this demonstration at four or more sites. The authorizing legislation identified a package of mandatory services that each CNO has to provide. It also required that the demonstration have a capitated payment method modeled after the average adjusted per capita cost payment used with health maintenance organizations. Another provision of the legislation stipulated that an alternative capitation formula be implemented in at least one of the four sites. The participating organizations will assume full financial risk for the demonstration's mandatory service package. In addition to these services, Carondelet provides optional services such as homemaker/home health aide services and respite care. The project's evaluation will examine the feasibility and viability of a capitated nurse-coordinated service model.

Status: On September 30, 1992, Carondelet Health Services was awarded one of four contracts to conduct the CNO demonstration. During the project's development year, the Carondelet Health Services established its organizational protocol, marketing and enrollment plan, service delivery system, and data collection plan for implementation of the CNO demonstration. The 3-year operational phase of the demonstration began in January 1994 and continued in 1995. Abt Associates, Inc. was selected to evaluate the project and to provide technical assistance to the four CNO sites. Abt Associates, Inc., also was awarded the external quality assurance contract.

92-072 Community Nursing Organization Demonstration: Living at Home/Block Nurse Program

Project No.:	500-92-0052
Period:	September 1992–December 1996
Funding:	$ 193,938
Award:	Contract
Principal Investigator:	Linda Robertson
Awardee:	Living at Home/Block Nurse Program Ivy League Place, Suite 225 475 Cleveland Avenue North St. Paul, MN 55104
HCFA Project Officer:	Melissa McNiff Division of Aging and Disability
Mandate:	Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203)

Description: The purpose of the Community Nursing Organization (CNO) demonstration is to develop and evaluate a nurse case-managed health care delivery system that provides Medicare-covered home health services, ambulatory care services, and durable medical equipment to eligible beneficiaries. Section 4079 of Public Law 100-203 directed the Secretary of the Department of Health and Human Services to conduct this demonstration at four or more sites. The authorizing legislation identified a package of mandatory services that each CNO has to provide. It also required that the demonstration have a capitated payment method modeled after the average adjusted per capita cost payment used with health maintenance organizations. Another provision of the legislation stipulated that an alternative capitation formula be implemented in at least one of the four sites. The participating organizations assume full financial risk for the demonstration's mandatory service package. In addition to these services, the Living at Home/Block Nurse Program provides optional services such as homemaker/home health aide services and respite care. The project's evaluation will examine the feasibility and viability of a capitated nurse-coordinated service model.

Status: On September 30, 1992, the Living at Home/Block Nurse Program was awarded one of four contracts to conduct the CNO demonstration. During the project's developmental year, the Living at Home/Block Nurse Program established its organizational protocol, marketing and enrollment plan, service delivery system, and data collection plan for implementation of the CNO demonstration. The 3-year operational phase of the demonstration began in January 1994. Abt Associates, Inc. was selected to evaluate the project and to provide technical assistance to the four CNO sites. Abt Associates, Inc. also was awarded the external quality assurance contract.

92-073 Community Nursing Organization Demonstration: Visiting Nurse Service of New York (Formerly, Community Nursing Organization Demonstration)

Project No.:	500-92-0054
Period:	September 1992–December 1996
Funding:	$ 945,282
Award:	Contract
Principal Investigator:	Ruth Mitchell
Awardee:	Visiting Nurse Service of New York 107 East 70th Street New York, NY 10021-5087

HCFA Project Officer: Thomas Theis
Division of Aging and Disability

Mandate: Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203)

Description: Section 4079 of Public Law 100-203 directs the Secretary of the Department of Health and Human Services to conduct demonstration projects at four or more sites to test a capitated, nurse-managed system of care. The two fundamental elements of the Community Nursing Organization (CNO) demonstration are capitated payment and nurse case management. These two elements are designed to promote timely and appropriate use of community health services and reduce the use of costly acute care services. The legislation mandates a CNO service package that includes home health care, durable medical equipment, and certain ambulatory care services. Four applicants were awarded site demonstration contracts on September 30, 1992. The selected sites represent a mix of urban and rural sites and different types of health providers, including a home health agency (HHA), a hospital-based system, and a large multispecialty clinic. The four sites are the following:

- Visiting Nurse Service of New York, New York, is the largest nonprofit Medicare-certified HHA in the United States.
- Living at Home/Block Nurse Program, St. Paul, Minnesota, is a nursing organization dedicated to assisting communities in replicating the Living at Home/ Block Nurse Program model of local volunteer and nursing support for the elderly.
- Carle Clinic Association, Mahomet, Illinois, one of the largest multispecialty physician group practices in the United States, functions as the regional medical center for the rural population that resides in Central Illinois and Western Indiana and serves nearly 2,000 patients daily.
- Carondelet Health Services, Inc., Tucson, Arizona, a group of three hospitals, a family center, and 17 community health centers, is sponsored by the Sisters of St. Joseph of Carondelet.

Status: All four CNO demonstration sites have undergone a 1-year development period and begun a 3-year operational period in January 1994, which continued in 1995. Abt Associates, Inc. was selected to evaluate the project and to provide technical assistance to the four CNO sites. Abt Associates, Inc. also was awarded the external quality assurance contract.

94-038 Community Nursing Organization Demonstration External Quality Assurance

Project No.: 500-92-0014DO04
Period: July 1994–July 1997
Funding: $ 535,304
Award: Delivery Order in Master Contract
Principal Investigator: David Kidder, Ph.D.
Awardee: Abt Associates, Inc.
(See page 203)
HCFA Project Officer: Melissa McNiff
Division of Aging and Disability

Mandate: Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203)

Description: The purpose of the Community Nursing Organization (CNO) Demonstration External Quality Assurance project is to conduct an external review of the quality of health care delivered to Medicare beneficiaries participating in the CNO demonstration (a risk-reimbursed coordinated care program for home health and selected ambulatory services). The CNO Demonstration External Quality Assurance project includes a quarterly review of client medical records for a sample of clients receiving Medicare-covered mandatory CNO services, and a quarterly review of CNO assessments and provision of CNO interventions on a sample of all enrollees. Under this project, the awardee will be responsible for monitoring the quality of care management and health education services provided through the CNO and implementing corrective actions, when necessary. The quality of traditional Medicare home health services will be monitored. The awardee also will conduct a use review of the home health services provided to enrollees to validate or support changes in capitation payment rates. The evaluation contractor will be provided with accurate and complete documentation of the findings and interventions of the quality assurance process.

Status: The developmental phase of the project has been completed, and quality reviews are being conducted.

93-077 Community-Supported Living Arrangements Program: Process Evaluation

Project No.: 500-92-0035DO02
Period: September 1993–August 1996
Funding: $ 411,941
Award: Delivery Order in Master Contract
Principal Investigator: Marilyn Ellwood
Awardee: SysteMetrics/MedStat
(See page 202)
HCFA Project Officer: Samuel L. Brown
Division of Aging and Disability

Mandate: Section 4712 of the Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: The Community-Supported Living Arrangements (CSLA) Program is designed to test the effectiveness of developing, under section 1930 of the Social Security Act, a continuum of care concept as an alternative to the Medicaid-funded residential services provided to individuals with mental retardation and related conditions (MR/RC) as an optional State plan service. The CSLA program serves individuals with MR/RCs who are living in the community either independently, with their families, or in homes with three or fewer other individuals receiving CSLA services. This model of care includes personal assistance; training and habilitation services necessary to assist individuals in achieving increased integration, independence, and productivity; 24-hour emergency assistance; assistive technology; adaptive technology; support services necessary to aid these individuals in participating in community activities; and other services, as approved by the Secretary of the Department of Health and Human Services. Costs related to room and board and to prevocational, vocational, and supported employment services are excluded from coverage. In accordance with the legislatively set maximum, California, Colorado, Florida, Illinois, Maryland, Michigan, Rhode Island, and Wisconsin have implemented CSLA programs. The purpose of this contract is to provide an evaluation of the CSLA program to the Health Care Financing Administration's Medicaid Bureau and Congress for their consideration of policy options regarding the continuation and/or expansion of the Medicaid State Plan optional service. The evaluation will address five areas:

- Philosophy or goals guiding States' CSLA programs.
- Description of CSLA programs with respect to recipients, types of services received, and the cost of such services.
- Description and discussion of quality assurance mechanisms being implemented.
- Exploration of the question of compatibility of the supported living concept with current goals and the structure of the Medicaid program.
- Exploration of the relationship between the supported living concept and the Americans with Disabilities Act.

Status: The contract was awarded on September 30, 1993. As of September 1995, the eight site visits to the participating States have been conducted. Seven of the eight State case studies have been received and are under review. Secondary data analysis will be conducted using data available from the participating CSLA States. A final evaluation report is expected in January 1996.

93-091 **Consumer Protection and Private Long-Term Care Insurance** (Formerly, Long-Term Care Studies (Section 207))

Project No.:	500-89-0047/16
Period:	December 1992–December 1994
Funding:	$ 130,000
Award:	Contract
Principal Investigator:	David Kennell
Awardee:	Lewin/VHI, Inc.
	(See page 148)
HCFA Project Officer:	Carolyn Rimes Division of Aging and Disability

Description: This study consists of a two-part analysis. The first is a policy-oriented synthesis of research conducted to date on long-term-care (LTC) insurance. The purpose of this synthesis is to serve as a baseline of understanding for policymakers and to identify relevant issues at which future research should be directed. The second part focuses on regulatory issues. This part contains case studies of Arizona, California, Florida, Indiana, North Dakota, New York, Oregon, South Carolina, Texas, and Wisconsin, which have passed legislation to regulate private LTC insurance, and summarizes how insurance companies have responded to this regulation. This project will be carried out jointly by Lewin/VHI and the Brookings Institution.

Status: The policy-oriented synthesis has been completed. This synthesis discusses the growth of the LTC insurance market from fewer than 50,000 policies in 1984 to nearly 3 million sold in 1992. Although this growth is significant, the market penetration is less than expected; approximately 5 percent of the elderly have LTC insurance, while 70 percent purchase Medicap policies. The study reviews potential reasons for limited market penetration, including consumer confusion, barriers to coverage, marketing and sales abuses, concern over product value, and regulation. An analysis of the case studies has taken place, and the draft report has been reviewed. The final report is anticipated in January 1996.

93-092 **Costs of Medicare Skilled Nursing Facility Therapy Services** (Formerly, Long-Term Care Studies (Section 207))

Project No.:	500-89-0047/41
Period:	July 1993–December 1994
Funding:	$ 160,800
Award:	Contract
Principal Investigator:	David Kennell
Awardee:	Lewin/VHI, Inc.
	(See page 148)
HCFA Project Officer:	Carolyn Rimes Division of Aging and Disability

Description: Approximately two-thirds of all Medicare skilled nursing facility (SNF) stays involve physical, occupational, or speech therapy. The importance of therapy services to the Medicare SNF benefit suggests that changes over time in charges for this service, as well as the patterns of charges

between Part A and Part B, need to be tracked. This study employs Medicare provider analysis and reviews SNF data to examine the characteristics of patients who receive high and very high-intensity therapy services. It also analyzes episodes of illness of Medicare patients who experience an SNF stay to elucidate the relationship between SNF use and providers of Medicare services.

Status: A draft report was submitted to the Office of Research and Demonstrations. The final report is expected to be completed by December 1995.

94-074 Design and Implementation of Medicare Home Health Quality Assurance Demonstration

Project No.:	500-94-0054
Period:	September 1994–May 1999
Funding:	$ 3,234,881
Principal Investigator:	Peter W. Shaughnessy, Ph.D.
Award:	Contract
Awardee:	Center for Health Policy Research 1355 South Colorado Boulevard, Suite 706 Denver, CO 80222
HCFA Project Officer:	Elizabeth Mauser, Ph.D. Division of Aging and Disability

Description: Currently, Medicare's home health survey and certification process is primarily focused on structural measures of quality. Although this process provides important information about home health care, an approach based on patient outcome measures would substantially increase the Medicare program's capacity to assess and improve patient well-being. To address this need, the Medicare home health quality demonstration will test an approach to developing outcome-oriented quality assurance and promoting continuous quality improvement in home health agencies. The demonstration is designed to serve two purposes: increase Health Care Financing Administration's capacity to assess the quality of Medicare home health care services and increase home health care agencies' ability to systematically evaluate and improve patient outcomes. The proposed quality assurance approach would complement existing home health certification and review programs and could be used with current survey and certification and peer review organization intervening care screen approaches. The study's conceptual framework for home health quality assessment is based on home health outcomes measures developed under a HCFA-funded study by the University of Colorado, entitled "Development of Outcome-Based Quality Measures in Home Health Services" (Contract No. 500-88-0054).

Status: Fifty agencies have been recruited for this demonstration and are expected to begin demonstration operations in January 1996.

88-023 Development of Outcome-Based Quality Measures for Home Health Services

Project No.:	500-88-0054
Period:	September 1988–July 1994
Funding:	$ 1,965,389
Award:	Contract
Principal Investigator:	Peter Shaughnessy, Ph.D.
Awardee:	Center for Health Policy Research 1355 South Colorado Boulevard, Suite 706 Denver, CO 80222
HCFA Project Officer:	Elizabeth Mauser Division of Aging Disability

Description: This study began in late 1988 with funding from both the Health Care Financing Administration and the Robert Wood Johnson Foundation. Its purpose is to develop and test outcome-based measures or indicators of quality for Medicare home health services. The measures are designed for use in monitoring and comparing quality of home health care across agencies. The study was designed to have three phases. During the first 15-month development phase, a wide range of approaches to home health care quality assurance and quality measurement were examined. The second phase involved a general feasibility assessment to determine which quality measures to investigate. As a result of this phase, a set of outcome measures was developed. The measures include both end-result outcomes (i.e., measures of patient status and use) and intermediate-result outcomes (i.e., measures of nonphysiological or nonfunctional status). The measures were developed according to different types of patient care needs defined by a patient condition taxonomy termed Quality Indicator Groups (QUIGs). The QUIGs can be used to stratify patients into groups for purposes of examining within-condition quality measures or used as case-mix variables/risk factors to be employed in adjusting global outcomes for all patients or larger groups of patients. The third phase was designed to systematically collect data for assessing the reliability, validity, and utility of each outcome measure. In this phase, longitudinal data were collected to measure outcomes for approximately 3,000 patients from 49 home health agencies. Further, preliminary analysis from this phase resulted in an initial design for a Medicare home health quality assurance demonstration.

Status: The final report was submitted in July 1994. The report outlines the findings and conclusions from the final empirical phase of the study and presents the proposed home health outcomes measures system. The article, "Measuring and Assuring the Quality of Home Health Care," by Shaughnessy, P.W., Crisler, K.S., Schlenker, R.E., and Arnold, A.G., et al. summarizes the findings and appears in the *Health Care Financing Review*, 16 (1):35–67, Fall 1994.

94-023 Development of Outcome-Based Quality Assurance Measures for Small, Integrated Services Settings

Project No.:	HCFA-94-0952
Period:	July 1994–January 1996
Funding:	$ 22,750
Award:	Contract
Principal Investigator:	James Gardner, Ph.D.
Awardee:	The Accreditation Council 8100 Professional Place, Suite 204 Landover, MD 20785
HCFA Project Officer:	Samuel L. Brown Division of Aging and Disability

Description: The purpose of this contract is to determine the cost of applying outcome measures in small, integrated service settings. This study will provide a database to maintain information on quality reviews of organizations that serve people with disabilities, an analysis of individual and organizational variables that relate to desirable outcomes, and a final report that analyzes quality reviews conducted in accordance with the outcome-based performance measures developed by the Accreditation Council on Services for People with Disabilities. The results will be used to assess the quality of services in facilities serving people with chronic mental illness, physical challenges, and mental retardation in diverse settings such as supported independent living or intermediate care facilities for the mentally retarded. Of particular importance is the assessment of the extent to which the outcome-based performance measures can coexist with the traditional quality assurance variables, such as abuse, neglect, safety, health, and physical and psychological welfare.

Status: During the period September through December 1994, 7 organizations participated in the Accreditation Council's review process. During these reviews, staff from the Accreditation Council interviewed 54 people served by the 7 organizations. A total of 28 organization variables (e.g., types of services provided, license type, disabilities of people served, prior accreditation status) were analyzed with regard to outcome scores. Analysis of outcome data was also performed on the characteristics of the individual people who were interviewed. These characteristics include age, sex, disability, living arrangement, communication method, services obtained, and source of person's funding. A final report is due January 1996.

93-093 Effect of Geographic Variations on Medicare Capitation Rates for the Social Health Maintenance Organization, Program for All-Inclusive Care for the Elderly, and Community Nursing Organization Projects (Formerly, Long-Term Care Studies (Section 207))

Project No.:	500-89-0047/40
Period:	August 1993–November 1994
Funding:	$ 116,200
Award:	Contract
Principal Investigator:	David Kennell
Awardee:	Lewin/VHI, Inc. (See page 148)
HCFA Project Officer:	Carolyn Rimes Division of Aging and Disability

Description: The current method of determining capitation payments to be made by Medicare for several demonstration programs (including the Social Health Maintenance Organization, Program for All-Inclusive Care for the Elderly, and Community Nursing Organization) is based on the adjusted average per capita cost methodology, which was developed to establish capitation rates for the Tax Equity and Fiscal Responsibility Act health maintenance organizations. In the above demonstration programs, case-mix models were developed that included individual limitations in activities of daily living and instrumental activities of daily living. These variables are not available for all Medicare recipients; consequently, the local area adjustment needed to measure the cost of enrolling a particular set of persons cannot be made in the usual manner. In this study, synthetic estimates are used to develop appropriate geographic adjustments that can be used in conjunction with national-level data in establishing capitation rate formulas for these and other potential demonstrations.

Status: A draft report was submitted. The final report is expected to be completed in December 1995.

91-097 Elderly Wealth and Savings: Implications for Long-Term Care (Formerly, Long-Term-Care Studies (Section 207))

Project No.:	500-89-0047/17
Period:	June 1991–August 1995
Funding:	$ 126,000
Award:	Contract
Principal Investigator:	David Kennell
Awardee:	Lewin/VHI, Inc. (See page 148)
HCFA Project Officer:	Carolyn Rimes Division of Aging and Disability

Description: This study synthesizes what is known about the wealth of the elderly and includes recent empirical research conducted using the 1984 and 1989 Panel Study of Income Dynamics and the 1983, 1986, and 1989 Survey of Consumer Finances. The information in this study is pertinent to the issue of long-term care (LTC) for the elderly because much of the debate concerning expansion of the Federal role in LTC financing centers on the economic status of the elderly. A key issue in the debate is whether or not the elderly have the financial resources to pay for their own LTC cost directly or through the purchase of private LTC insurance.

Status: The main finding of the synthesis report is that the elderly, as a group, are doing well economically. Incomes of the elderly are lower than incomes of the nonelderly, but this gap narrows when taxes and other benefits (i.e., Medicare) are considered. Furthermore, the elderly have among the highest wealth holdings of any age group. However, the elderly face substantial economic risks, such as incurring unfunded catastrophic medical expenses, and leaving poverty is harder for the elderly than for the nonelderly. This study also finds that existing theories on both whether and why the elderly save sharply disagree with one another. Testing these theories is challenging because data sources are usually poor or out of date, and many of the theories do not yield refutable hypotheses. The final report has been received and is currently under review.

89-031 Evaluation and Technical Assistance of the Medicare Alzheimer's Disease Demonstration

Project No.:	500-89-0069
Period:	September 1989–May 1995
Funding:	$ 4,685,356
Award:	Contract
Principal Investigator:	Robert J. Newcomer, Ph.D.
Awardee:	Institute for Health and Aging University of California at San Francisco 201 Filbert Street Box 0646, Laurel Heights San Francisco, CA 94133-0646
HCFA Project Officer:	Dennis M. Nugent Division of Aging and Disability
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508) Omnibus Budget Reconciliation Act of 1993 (Public Law 103-66)

Description: The purpose of the Medicare Alzheimer's Disease Demonstration was to determine the effectiveness and cost of providing comprehensive in-home and community-based services to beneficiaries who have dementia and to assess the impact on health status and functioning. Two models of care were studied under this project. Both models included case management and a wide range of services, such as homemaker/personal care services, companion services, adult day care, family counseling, and caregiver education and training. The two models varied by the intensity of the case management provided to beneficiaries and their caregivers and the amount of demonstration service costs that could be paid for by Medicare each month. Some questions to be addressed by the evaluation are as follows:

- What factors are associated with the cost-effectiveness of providing an expanded package of home care and community-based services to Medicare beneficiaries with Alzheimer's disease or related disorders?
- How do various services affect the health status and functioning of dementia patients and their caregivers?
- What are the effects of providing community-based services on caregiver burden and stress?
- Do additional home care services delay or prevent the institutionalization of beneficiaries who have dementia?

Status: An experimental study design was used to measure the impact of the Medicare Alzheimer's Disease Demonstration on beneficiaries and their caregivers. The editing and analysis of the project's data are expected to be completed by May 1996. Preliminary findings reveal that most of the participating beneficiaries had Alzheimer's disease (66-75 percent). Other common diagnoses included vascular dementia and dementia resulting from degenerative conditions such as Parkinson's, Huntington's, and Pick's diseases. The level of beneficiary impairment was high, averaging over 5 limitations in 10 activities of daily living, (e.g., walking, bathing, toileting, eating, transferring) and more than 7 limitations in 8 instrumental activities of daily living, (e.g., meal preparation, shopping, housework, money management). The majority of the beneficiaries who were enrolled in the demonstration were female (60 percent), and white (88 percent). Their average age was 79. Case management was used by 95 percent of project participants.

This contract expired in May 1995. The analysis of the project's data and the final Report to Congress are being completed under a new contract with the University of California, San Francisco. The final Report to Congress will provide evaluation findings and identify recommendations for legislative consideration.

95-073 Evaluation and Technical Assistance of the Medicare Alzheimer's Disease Demonstration

Project No.:	500-95-0015
Period:	May 1995–September 1996
Funding:	$ 802,642
Award:	Contract
Principal Investigator:	Robert J. Newcomer, Ph.D.
Awardee:	Institute for Health and Aging University of California, San Francisco 201 Filbert Street Box 0646, Laurel Heights San Francisco, CA 94133-0646
HCFA Project Officer:	Dennis M. Nugent Division of Aging and Disability
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508) Omnibus Budget Reconciliation Act of 1993 (Public Law 103-66)

Description: The purpose of the Medicare Alzheimer's Disease Demonstration was to determine the effectiveness, cost, and impact on health status and functioning of providing comprehensive in-home and community-based services to beneficiaries who have dementia. Two models of care were studied under this project. Both models included case management and a wide range of services, such as homemaker/personal care services, adult day care, companion services, caregiver education, and family counseling. The two models varied by the intensity of the case management provided to beneficiaries and their caregivers and the amount of demonstration service costs that could be paid for by Medicare each month. Some questions to be addressed by the evaluation are as follows:

- What factors are associated with the cost- effectiveness of providing an expanded package of home care and community-based services to Medicare beneficiaries with Alzheimer's disease or related disorders?
- How do various services affect the health status and functioning of dementia patients and their caregivers?
- What are the effects of providing community-based services on caregiver burden and stress?
- Do additional home care services delay or prevent institutionalization of beneficiaries with dementia?

Status: The Medicare Alzheimer's Disease Demonstration was extended twice by congressional legislation. Because of the length of the project, the original Evaluation and Technical Assistance contract with the University of California, San Francisco expired before the conclusion of the evaluation. This current contract was awarded to enable the University of California, San Francisco to complete the project's data analysis and the final Report to Congress. The Report to Congress will present evaluation findings and include recommendations for possible legislative changes.

92-068 Evaluation of the Community Nursing Organization Demonstration

Project No.:	500-92-0055
Period:	September 1992–February 1997
Funding:	$ 2,414,634
Award:	Contract
Principal Investigator:	Robert J. Schmitz, Ph.D.
Awardee:	Abt Associates, Inc. 55 Wheeler Street Cambridge, MA 02138
HCFA Project Officer:	Melissa McNiff, M.P.S. Division of Aging and Disability
Mandate:	Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203)

Description: The Community Nursing Organization (CNO) Demonstration was mandated by section 4079 of the Omnibus Budget Reconciliation Act of 1987. The legislation directs the Secretary of the Department of Health and Human Services to conduct a demonstration project at four or more sites to test a capitated, nurse-managed system of care. The two fundamental elements of the CNO are capitated payment and nurse case management. These two elements are designed to promote timely and appropriate use of community health services and to reduce the use of costly acute care services. The legislation mandates a CNO service package that includes home health care, durable medical equipment, and certain ambulatory care services. The CNO sites receive a monthly capitation payment for each enrollee. The capitation rate is modeled on the average adjusted per capita cost payment method used for Medicare health maintenance organizations. The CNO per capita payment rate will be set at a level that is equal to 95 percent of the adjusted average per capita Medicare payment for community and ambulatory services in the CNO's geographic area. The legislation mandates the use of two types of CNO per capita payment methods. Payment Method A adjusts the per capita payment according to an individual's age, gender, and prior home health use. Payment Method B adjusts the per capita payment according to an individual's functional status in addition to age, gender, and prior home health use. The evaluation of the CNO demonstration will test the feasibility and effect on patient care of a capitated, nurse case-managed service delivery model. Both qualitative and quantitative components are included in the evaluation design. The qualitative component will use a case study approach to examine the operational and financial viability of the CNO model. The quantitative component will use a randomized design to

measure the impact of the CNO intervention on mortality, hospitalization, physician visits, nursing home admissions, and Medicare expenditures, as well as on such nurse-sensitive outcomes as knowledge of health problems and management of care.

Status: The four CNO demonstration sites completed a 1-year developmental period and began a 3-year operational period in January 1994. Collection of baseline data for CNO enrollees began in January 1994. A site visit report summarizing site activities in the 1-year development period was received in July 1994. An interim report is due in early 1996.

90-065 Evaluation of the Home Health Prospective Payment Demonstration

Project No.:	500-90-0047
Period:	September 1990–November 1995
Funding:	$ 2,858,676 (Phase I)
Award:	Contract
Principal Investigator:	Randall S. Brown, Ph.D.
Awardee:	Mathematica Policy Research, Inc. P.O. Box 2393 Princeton, NJ 08543-2393
HCFA Project Officer:	Elizabeth Mauser, Ph.D. Division of Aging and Disability
Mandate:	Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203)

Description: The purpose of this contract is to evaluate Phase I of a demonstration designed to test the effectiveness of using prospective payment methods to reimburse Medicare-certified home health agencies (HHA) for services provided under the Medicare program. In Phase I, a per visit payment method that sets a separate payment rate for each of six types of home health visits (skilled nursing, home health aide, physical therapy, occupational therapy, speech therapy, and medical social services) is being tested. Mathematica Policy Research is evaluating the effects of this payment method on HHAs' operations, service quality, and expenditures. The awardee is also analyzing the relationship between patient characteristics and the cost and utilization of home health services.

Status: By October 1994, all demonstration agencies exited the demonstration. Mathematica has submitted a preliminary impact report based on the findings from the first year of the demonstration. These preliminary findings suggest that treatment agencies have not decreased their cost per visit, have increased their total revenues and net revenues, or have altered their behavior in ways that affect the quality of home health care. The article "Do Preset Per Visit Payment Rates Affect Home Health Agency Behavior?" by Phillips, B.R., Brown, R.S., Bishop, C.E., and Klein, A.C. discusses preliminary results from Phase I of the demonstration and appears in the *Health Care Financing Administration*, 16(1):91-107, Fall 1994. Findings from the full demonstration thus far suggest that per visit prospective payment had no significant effect on quality of care, selection and retention of patients, use of non-Medicare services, and use and reimbursement of Medicare-covered services. But it appears that treatment agencies may have responded to the opportunities to earn profits under the demonstration by increasing their volume of visits faster than they would have in the absence of prospective rate setting.

94-081 Evaluation of the Nursing Home Case-Mix and Quality Demonstration

Project No.:	500-94-0061
Period:	September 1994–September 1999
Funding:	$ 2,980,219
Award:	Contract
Principal Investigator:	Robert J. Schmitz, Ph.D.
Awardee:	Abt Associates, Inc. 55 Wheeler Street Cambridge, MA 02138
HCFA Project Officer:	Ellen O'Brien Division of Aging and Disability

Description: Under the Nursing Home Case-Mix and Quality Demonstration, the Health Care Financing Administration is testing the feasibility of paying skilled nursing facilities (SNFs) for Medicare skilled nursing services on a prospective basis. Currently, SNFs are reimbursed on a retrospective basis for their reasonable costs. A case-mix classification, called Resource Utilization Groups, is being used to classify patients, permitting HCFA to pay facilities for each covered day of care, according to the case mix of patients residing in the facility on any given day. Though some costs will continue to be paid on a retrospective cost basis under the demonstration, the prospective rate will include inpatient routine nursing costs and therapy costs. To guard against the possibility that inadequate care would be provided to patients with heavy care needs, a system of quality indicators has been developed that will be used to monitor the quality of care.

The demonstration project was implemented in six States (Kansas, Maine, Mississippi, New York, South Dakota, and Texas) in Summer 1995, with Medicare-certified facilities in these States being offered the opportunity to participate on a voluntary basis.

The evaluation of this demonstration project will seek to estimate specific behavioral responses to the introduction of prospective payment and to test hypotheses about certain aspects of these responses. The principal goal of the evaluation of the Nursing Home Case-Mix and Quality Demonstration is the estimation of the effects of case-mix-adjusted prospective payment on the health and functioning

of nursing home residents, their length of stay, and use of health care services; on the behavior of nursing facilities; and on the level and composition of Medicare expenditures.

Status: A final evaluation design report is currently being prepared by the contractor.

94-082 Evaluation of Phase II of the Home Health Agency Prospective Payment Demonstration

Project No.:	500-94-0062
Period:	September 1994–September 1999
Funding:	$ 3,528,408
Award:	Contract
Principal Investigator:	Barbara Phillips, Ph.D.
Awardee:	Mathematica Policy Research, Inc. P.O. Box 2393 Princeton, NJ 08543-2393
HCFA Project Officer:	Elizabeth Mauser, Ph.D. Division of Aging and Disability
Mandate:	Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203)

Description: This contract will evaluate Phase II of the Home Health Agency Prospective Payment Demonstration. This demonstration is testing two alternative methods of paying home health agencies (HHA) on a prospective basis for services furnished under the Medicare program. The prospective payment approaches being tested include payments per visit by type of HHA visit discipline (Phase I) and payment per episode of Medicare-covered home health care (Phase II). Implementation of Phase II, which will test the per episode payment approach, is scheduled to begin in Spring 1995. HHAs that agree to participate are randomly assigned to either the prospective payment method or to a control group that continues to be reimbursed in accordance with the current Medicare retrospective cost system. HHAs will participate for 3 years. The evaluation will combine estimates of program impacts on cost, service use, access, and quality, with detailed information on how agencies actually change their behavior to produce a full understanding of what would happen if prospective payment replaced the current cost-based reimbursement system nationally. The findings will indicate not only the overall effects of the change in payment methodology, but also how the effects are likely to vary with the characteristics of agencies and patients. This information will be of great value for estimating the potential savings from a shift to prospective payment for home health care, for indicating where potential problems with quality of care might exist, and for identifying types of patients who might be at risk of restricted access to care as a result of their need for an unusually large amount of care. Because of the relatively small number of agencies participating, the use of qualitative information obtained in discussions with agencies concerning their characteristics and behavior will be essential for avoiding erroneous inferences.

Status: Site visits to participating agencies are scheduled to begin in November 1995.

91-017 Evaluation of the Program of All-Inclusive Care for the Elderly Demonstration

Project No.:	500-91-0027
Period:	June 1991–June 1996
Funding:	$ 4,486,514
Award:	Contract
Principal Investigator:	David Kidder, Ph.D.
Awardee:	Abt Associates, Inc. 55 Wheeler Street Cambridge, MA 02138
HCFA Project Officer:	Elizabeth Mauser, Ph.D. Division of Aging and Disability
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: The Program of All-Inclusive Care for the Elderly (PACE) Demonstration replicates a unique model of managed care service delivery for 300 very frail community-dwelling elderly, most of whom are dually eligible for Medicare and Medicaid coverage and all of whom are assessed as being eligible for nursing home placement according to the standards established by participating States. The model of care includes as core services the provision of adult day health care and multidisciplinary team case management through which access to and allocation of all health and long-term care services are arranged. This model is financed through prospective capitation of both Medicare and Medicaid payments to the provider. One purpose of the evaluation is to examine PACE sites before and after assumption of full financial risk, with the purpose of determining whether the PACE model of care, as a replication of the On Lok Senior Health Services model of care, is cost-effective relative to the existing Medicare and Medicaid programs. Another purpose is to examine the decision to enroll in PACE in order to understand how PACE enrollees differ from those who are eligible for PACE but refuse to enroll in the program; to determine the impact of PACE on participant health services utilization, expenditures, and outcomes; and to explore the subobjectives of PACE or the link between PACE and the outcomes of interest.

Status: This project initiated primary data collection in January 1995 that will continue through June 1996. Reports based on site visits to demonstration sites operating under capitated Medicare and Medicaid payments have been received from the awardee and are being reviewed.

93-094 **Examination of the Relation of Part A and Part B Medicare Expenditures** (Formerly, Long-Term Care Studies (Section 207))

Project No.:	500-89-0047/9
Period:	December 1992–November 1994
Funding:	$ 175,300
Award:	Contract
Principal Investigator:	David Kennell
Awardee:	Lewin/VHI, Inc.
	(See page 148)
HCFA Project Officer:	Carolyn Rimes
	Division of Aging and Disability

Description: This study is an extension of the analyses of the acute care costs of chronically disabled persons completed using the 1984–89 National Long-Term Care Survey (NLTCS). This analysis employs recently released 1989 NLTCS data to examine possible cost shifts for groups of persons with very different levels of health and functioning. Analyses were made of seven different categories of Medicare service (short-stay hospital, home health agency, skilled nursing facility, physician, outpatient, durable medical equipment, and renal therapy) for 1982 to 1990 using Medicare records linked to data on community and institutional residents from NLTCS 1982, 1984, and 1989. The purpose of the combined survey and administrative record analyses was to ascertain how the chronic health and functional characteristics of community and institutional residents using Medicare-reimbursed services changed over the period and how those changes related to the use of each of seven categories of Medicare services. Over this period, a number of regulatory and legislative changes had been made in the Medicare system that altered the use of different services by persons with specific health and functional profiles.

Status: The final report has been received and will be included in the proceedings from the Brookings Conference.

93-069 **External Assessment of Quality Assurance in the Program for All-Inclusive Care for the Elderly**

Project No.:	500-92-0014DO02
Period:	September 1993–March 1996
Funding:	$ 389,218
Award:	Delivery Order in Master Contract
Principal Investigator:	David Kidder, Ph.D.
Awardee:	Abt Associates, Inc.
	(See page 203)
HCFA Project Officer:	Elizabeth Mauser, Ph.D.
	Division of Aging and Disability
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509)
	Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203)
	Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: The purpose of this study is to develop and test an external quality assurance program for the Program for All-Inclusive Care for the Elderly (PACE) model of care. These measures may be used by the Health Care Financing Administration and State Medicaid agencies in quality assurance monitoring of the PACE program. The two key approaches that form the basis for the development of a quality assurance program are (1) a "tracer approach" that identifies certain events whose existence represents a sign of unsatisfactory care and (2) "general patient-centered measures" of health outcomes that reflect the total effects of care on the individual patient. The quality assurance approach encompasses both process and outcome elements.

Status: Tracer conditions have been developed by the University of Minnesota, the subcontractor for this delivery order. The University of Minnesota has obtained copies of medical records from each of the PACE sites and has abstracted the necessary information from the medical records. A report describing the findings from the medical records has been submitted. Additional reports will be submitted that include information about patient satisfaction and the feasibility of conducting this type of monitoring system on a group of control patients.

93-095 **Health Care Service Use and Expenditures of the Noninstitutionalized Population** (Formerly, Long-Term Care Studies (Section 207))

Project No.:	500-89-0047/8
Period:	June 1993–February 1995
Funding:	$ 148,000
Award:	Contract
Principal Investigator:	David Kennell
Awardee:	Lewin/VHI, Inc.
	(See page 148)
HCFA Project Officer:	Carolyn Rimes
	Division of Aging and Disability

Description: Using data from the 1987 National Medical Expenditures Survey Household Component, this study addresses the following:

- Differences in the utilization of health care services by disabled and nondisabled populations.
- Whether community-based long-term-care services and expenditures substitute for acute-care expenditures for the population using community-based long-term care services and the implications for costs.
- Medicaid asset spenddown in the community.
- Trends in out-of-pocket expenditures and total health care expenditures for the elderly population with comparisons to the 1977 National Medical Care Expenditure Survey.

Status: Analysis files have been constructed. A draft report has been completed. The final report is expected in January 1996.

90-011 Home Care Quality Studies

Project No.:	500-89-0056
Period:	October 1989–September 1995
Funding:	$ 2,848,782
Award:	Contract
Principal Investigator:	Robert L. Kane, M.D.
Awardee:	The University of Minnesota School of Public Health D-351 Mayo Memorial Building 420 Delaware Street, SE., Box 197 Minneapolis, MN 55455-0392
HCFA Project Officer:	Phyllis A. Nagy Division of Aging and Disability

Description: This study examines quality of long-term care services in community-based and custodial settings, and the effectiveness of (and need for) State and Federal protections for Medicare beneficiaries that ensure adequate access to nonresidential long-term care services and protection of consumer rights. The research design focuses on in-home care, examining traditional home health services that are reimbursed by Medicare and Medicaid, as well as personal care and supportive services that more recently have been covered by Federal and State sources of funding. Primary project tasks include the following:

- Development of a taxonomy clarifying the various objectives ascribed to home and community-based care from the various perspectives of consumers, payers, and care providers.
- Development and feasibility testing of a survey design measuring the extent of, need for, and adequacy of home care services for the elderly.
- A study of variations in labor supply and related effect(s) on home care quality, as well as factors that contribute to these variations.
- Recommendations to improve the quality of home and community-based services by identifying best practices and promising quality assurance approaches.

Status: The first project task (development of a taxonomy of objectives) has been completed, and a report on this component has been received. Findings from this task are presented in the article, "Perspectives on Quality of Home Care" by Kane, R.A., Kane, R.L., Illston, L.H., and Eustis, N.N. in the *Health Care Financing Review*, 16(1):69-89, Fall 1994. Final reports have also been submitted on the remaining three project tasks (i.e., developing a survey to measure the adequacy of home care for the elderly, a study of variations in labor supply and related effects on home care quality, and an identification of best home care practices and promising quality assurance approaches). A draft final report for the project was submitted in October 1995.

90-021 Implementation of the Home Health Agency Prospective Payment Demonstration

Project No.:	500-90-0024
Period:	June 1990–November 1995
Funding:	$ 1,629,606
Award:	Contract
Principal Investigator:	Henry Goldberg
Awardee:	Abt Associates, Inc. 55 Wheeler Street Cambridge, MA 02138
HCFA Project Officer:	J. Donald Sherwood Division of Payment Systems
Mandate:	Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203)

Description: This contract implements and monitors the demonstration design for the Home Health Agency Prospective Payment Demonstration, which was developed under an earlier contract with Abt Associates, Inc. Under this project, two methods of paying home health agencies (HHA) on a prospective basis for services furnished under the Medicare program will be tested. The prospective payment approaches to be tested include payments per visit by type of discipline (Phase I), and payments per episode of Medicare-covered home health care (Phase II). HHA participation is voluntary. In each phase, HHAs that agree to participate are randomly assigned to either the prospective payment method or to a control group that continues to be reimbursed in accordance with the current Medicare retrospective cost system. HHAs will participate in the demonstration for 3 years.

Status: Following an initial recruitment of HHAs, operations under Phase I were implemented on October 1, 1990. Forty-nine HHAs were recruited. All agencies under Phase I completed their 3-year participation as of October 1994. An evaluation of Phase I is being conducted by Mathematica Policy Research, Inc., through a separate contract. Recruitment for Phase II agencies began in fall 1994. The implementation of Phase II, the per episode payment phase, will be conducted by Abt Associates under a separate contract.

94-062 Implementation of the Multistate Nursing Home Case-Mix and Quality Demonstration

Project No.:	500-94-0010
Period:	February 1994–July 1996
Funding:	$3,209,538
Award:	Contract
Principal Investigator:	Robert E. Burke, Ph.D.
Awardee:	Allied Technology Group, Inc. 1803 Research Boulevard, Suite 601 Rockville, MD 20850
HCFA Project Officer:	Elizabeth S. Cornelius Division of Payment Systems

Description: This contract will support the implementation phase of the Multistate Nursing Home Case-Mix and Quality Demonstration. The demonstration combines the Medicare and Medicaid nursing home payments and quality monitoring system across several States: Kansas, Maine, Mississippi, New York, South Dakota, and Texas. This project builds on past and current initiatives with case-mix payment and quality assurance in nursing homes. The purpose of the demonstration is to test a resident information system with variables for classifying residents into homogeneous resource utilization groups for equitable payment and for quality monitoring of process and outcomes adjusted for case mix. The project will have three phases: systems design and development, systems implementation and monitoring, and evaluation.

The objectives of the implementation phase are as follows:

- Recruit facilities in the six demonstration States to participate in the Medicare portion.
- Develop and operate the Medicare case-mix system of the demonstration for the Health Care Financing Administration that involves the fiscal intermediaries and the Medicare skilled nursing facility (SNF) providers.
- Develop a valid therapy payment component for inclusion in the Medicare case-mix payment rate.
- Conduct a staff-time measurement study to validate the Resource Utilization Group, Version III (RUG III) classification system.
- Validate the quality indicators (QIs) and implement the quality monitoring system in the demonstration States through the States' nursing home survey process.
- Implement an administrative management and operational system that links distinct components of the demonstration (e.g., classification of residents, Medicare coverage determination, payment systems, outcome monitoring for quality, assessment reliability).
- Implement a field auditing system that monitors States and nursing homes participating in the Medicare portion.

Status: In July 1993, implementation of the Medicaid prospective payment systems was begun, with full participation in 1994. Maine, Mississippi, and Kansas are beginning to routinely use the QI reports in the survey and certification process as of October 1995, based on the pilot test report and the first nine validation visits.

In Fall 1995, there are 2,088 Medicare SNFs in the 6 demonstration States, in contrast to 1,120 in 1990. There were 1,914 invitations sent to providers in December 1994, with over 1,000 responses received expressing interest in further information by summer 1995. Phase I operation of the Medicare prospective payment system began in July 1995. By Fall 1995, there were 300 facilities being paid for routine services using the 3 regional Multistate Medicare Payment Indices.

The RUG III validation staff-time measurement data collection was completed in 7 States by July 1, 1995, including the minimum data set 2.0 (MDS2.0) on 2,056 residents across approximately 80 study units in seven States, not counting New York. Data collection in New York will be completed in early 1996 and added to the validation database. The resident level validation data file is currently being compiled. The multiple analyses will be carried out during winter 1995, with the rehabilitation (occupational, physical, and speech therapy) index added to the Medicare payment system in spring 1996.

Phase II of the Medicare portion of the demonstration will begin at the start of providers' fiscal years beginning January 1, 1996. In January 1996 and each calendar year thereafter to the end of the demonstration, the prospective rates will be inflated on January 1st. Phase III of the demonstration, when the rehabilitation therapies will be added to the prospective payment, will begin April 1996 in the fiscal year of the provider. Recruitment of SNF participation will end in 1997.

91-055 Interaction of Medicaid and Private Long-Term Care Insurance

Project No.:	99-C-98526/1
Period:	August 1991–July 1993
Funding:	$80,000
Award:	Cooperative Agreement

Principal Investigator:	Christine Bishop, Ph.D.
Awardee:	Brandeis University Heller Graduate School Institute for Health Policy 415 South Street, P.O. Box 9110 Waltham, MA 02254-9110
HCFA Project Officer:	Judith A. Sangl, Sc.D. Division of Health Information and Outcomes

Description: For this study, researchers will examine the characteristics of purchasers and nonpurchasers of private long-term-care (LTC) insurance, the types of insurance purchased, and the role of State Medicaid program characteristics and personal characteristics in influencing the purchase decision.

Status: The study found that after accounting for available control variables, purchase of private LTC insurance is less likely where Medicaid supports a relatively high level of input intensity in nursing homes, where nursing home beds are more available, and where higher income persons may be eligible for Medicaid as "medically needy" because of nursing home spending. These results suggest that the Medicaid "safety net" deters LTC insurance purchase and that improvements in Medicaid coverage of LTC may further suppress demand for private LTC insurance. An additional analysis examined the factors related to an individual's decision to purchase a given amount of LTC insurance. Advancing age, being married, and having less than a college education were negatively associated with the expected value of policy coverage. Variables positively related with the dependent variable include being male, having more income, and having increasing expected LTC costs. Medicaid program configuration also influences the level of benefits purchased: States' reimbursement rates and the presence of comprehensive estate recovery programs are both positively related to the expected value of purchased benefits. Finally, as the difference between the premium charged and the actuarially fair premium increases, individuals buy less coverage. These results were published in *Health Services Research* 29(6):653-678.

94-045 Interrelationship of Medical Conditions in the Nursing Home Population

Project No.:	500-89-0047/43
Period:	January 1994–December 1995
Funding:	$ 67,600
Award:	Contract
Principal Investigator:	David Kennell
Awardee:	Lewin/VHI, Inc. (See page 148)
HCFA Project Officer:	Carolyn Rimes Division of Aging and Disability

Description: This project, conducted in collaboration with the Health Care Financing Administration, uses concatenated Medicare provider analysis and review, skilled nursing facility (SNF), and minimum data set plus data to develop a richer profile of Medicare SNF patients. Data for all patients include their clinical conditions, their subsequent use of Medicare hospital and SNF services, and their use of their non-Medicare-covered nursing home services. This is a pilot study that focuses on three States (Maine, Mississippi, and South Dakota) and on patients with selected conditions (congestive heart failure, hip fracture/replacement, chronic obstructive pulmonary disease, pneumonia, and cardiovascular attack). This study also examines the characteristics of nursing home patients who are under 65 years of age. This work has been subcontracted to The Urban Institute.

Status: This project is expected to be completed in February 1996.

92-099 Issues in Long-Term Care Policy for the Disabled Elderly with Cognitive Impairment (Formerly, Long-Term Care Studies (Section 207))

Project No.:	500-89-0047/21
Period:	January 1992–March 1995
Funding:	$ 180,000
Award:	Contract
Principal Investigator:	David Kennell
Awardee:	Lewin/VHI, Inc. (See page 148)
HCFA Project Officer:	Carolyn Rimes Division of Aging and Disability

Description: This study utilizes the National Long-Term Care (NLTC) surveys to analyze issues related to informal caregiving to cognitively impaired elderly people, the mix of formal and informal services they use, and the risk of institutionalization. The main question addressed is whether the presence of such factors as behavioral problems or conditions (e.g., incontinence) that imply special service needs affect the mix of services used or the risk of institutionalization. This work will be completed by Judith Kasper of the Johns Hopkins University School of Hygiene and Public Health under subcontract to Lewin/VHI.

Status: The article, "Cognitive Impairment and Problem Behaviors as Risk Factors for Institutionalization," by Judith Kasper and Andrew D. Shore, describes the first part of this study and appears in the *Journal of Applied Gerontology*, 13(4):371–385, December 1994. The NLTC survey data were used to develop a predictive model for nursing home institutionalization that includes cognitive functioning and problem behaviors in addition to more commonly studied indicators, such as disability. As expected, cognitive impairment is a risk factor for institutionalization, controlling

for other characteristics such as age, living arrangement, and use of paid in-home care. Four problem behaviors were investigated, but only one, Wanders/Gets Lost, contributed to the model. Among cognitively impaired persons, those who wander/get lost had a twofold risk of institutionalization. The findings suggest the need to differentiate among difficult or problem behaviors and to further investigate those that arouse concerns about safety and require extensive supervision as risk factors for institutionalization. The second part of this study that examines survey data combined with Medicare claims will be completed by December 1995.

93-096 **Key Issues for Private Long-Term Care Insurance** (Formerly, Long-Term Care Studies (Section 207))

Project No.:	500-89-0047/18
Period:	December 1992–December 1994
Funding:	$ 167,900
Award:	Contract
Principal Investigator:	David Kennell
Awardee:	Lewin/VHI, Inc.
	(See page 148)
HCFA Project Officer:	Carolyn Rimes
	Division of Aging and Disability

Description: Although the number of private long-term care (LTC) insurance policies in force has grown substantially over the past few years, there continue to be concerns about the ultimate market penetration and the form policies will take. In addition, there is a variety of legislative proposals and strategies that would affect the role of private LTC insurance. This study addresses key issues for private long-term care insurance. The three components of this study are an assessment of key standards currently being debated (e.g., rate stabilization), an assessment of current policies, and a paper detailing the possible post reform roles of private LTC insurance. This project will be carried out jointly by Lewin/VHI and the Brookings Institution.
Status: A draft report has been completed. The final report is expected in January 1996.

94-044 **Longitudinal Health Care Use and Expenditures of Disabled Persons**

Project No.:	500-89-0047/42
Period:	January 1994–June 1995
Funding:	$ 143,000
Award:	Contract
Principal Investigator:	David Kennell
Awardee:	Lewin/VHI, Inc.
	(See page 148)
HCFA Project Officer:	Carolyn Rimes
	Division of Aging and Disability

Description: This project, conducted in collaboration with the Health Care Financing Administration, uses data from the Medicare Current Beneficiary Survey to examine health care use by persons with disabilities and the cost of providing these services. In this study, Medicare beneficiaries are categorized by different definitions of disability and by duration of disability. An analysis of the types of health care services and patterns of use for each subgroup is performed to determine the extent to which differences in such constructs are associated with differences in health care use and costs. This study is designed, in part, to provide information parallel with that from Lewin/VHI's analysis of National Medical Care Expenditure Survey data and Duke University's analysis of National Long-Term Care Survey data. This work has been subcontracted to The Urban Institute.

Status: Delays have been experienced on the release of the "1992 Public Use File for Cost and Use." This project is dependent on those files. The final report is expected to be completed in March 1996.

89-030 **Long-Term Care Case-Mix and Quality Technical Design Project**

Project No.:	500-89-0046
Period:	September 1989–December 1993
Funding:	$ 3,097,982
Award:	Contract
Principal Investigator:	Robert E. Burke, Ph.D.
Awardee:	The Circle, Inc.
	8201 Greensboro Drive, Suite 600
	McLean, VA 22102
HCFA Project Officer:	Elizabeth S. Cornelius
	Division of Payment System

Description: This 4-year contract has supported the design phase of the multistate Nursing Home Case-Mix and Quality (NHCMQ) Demonstration. The demonstration combines the Medicare and Medicaid nursing home payment and quality monitoring system across several States: Kansas, Maine, Mississippi, New York, South Dakota, and Texas. This project builds on past and current initiatives with case-mix payment and quality assurance in nursing homes. The purpose is to test a resident information system with variables for classifying residents into homogeneous resource use groups for equitable payment and for quality monitoring of process and outcomes adjusted for case mix. The project will have three phases: systems design and development, systems implementation and monitoring, and evaluation.

Status: The classification system to be used for Medicare and Medicaid across the demonstration States was completed in June 1991 by researchers from the University of Michigan and Rensselaer Polytechnic Institute. The Resource Utilization Group, Version III (RUG-III), uses 44 groups to explain approximately 45 percent of the variance in nursing staff time and 52 percent of the costs across nursing, occupational therapy, physical therapy, speech pathology, transportation, and social work services. RUG-IIIs are split on clinical conditions, including signs and symptoms of distress, type and intensity of service, and activities of daily living. The 27 groups at the top of the classification system closely correlate with the Medicare coverage criteria. Five papers covering the analyses done on developing the classification system have been published. A working paper, "Description of the Resource Utilization Group, Version III (RUG-III)," which describes the classification, is available from the Division of Long-Term Care Experimentation. The common assessment tool, the minimum data set plus (MDS+), has been developed and implemented as the State resident assessment instrument in the demonstration States. A training manual that includes the MDS+ and the resident assessment protocols has been published: Feldman, J., and Boulter, C., eds.: *Minimum Data Set Plus (MDS+). Multistate Nursing Home Case-Mix and Quality Demonstration Training Manual.* Natick, MA. Eliot Press, 1991. Four Medicaid systems have been implemented at the present time. The analysis of 1990 Medicare Cost Reports and 1990 case-mix data to develop the Medicare payment design are completed. A working paper, "Issue Paper on Development of Medicare SNF Payment Rates," was developed and distributed to persons working on the payment system design. The Medicare payment system portion of the demonstration was implemented in July 1995 under a separate contract. Under a subcontract with The Circle, the University of Wisconsin's researchers developed a preliminary list of 31 facility-level quality indicators (QI) that were used in a 4-State pilot test. They were reviewed by expert surveyors from the 6 States, a research-oriented quality panel, and a clinical work group of 60 health professionals representing about 15 disciplines working in long-term care. A paper describing the analyses done and issues addressed in developing the QIs was published in the Summer 1995 issue of the *Health Care Financing Review.* The QIs will serve to enhance the quality assurance process to be used for the operational phase. The final set of QIs will be implemented throughout the demonstration in 1995. The final report of the technical design phase of the multistate NHCMQ Demonstration, including appendixes, has been received and is under review. The products of the design phase include several software programs:

- A modified 1.01 version of Malitz, D., Ph.D., and Godbout, R.C., Ph.D.: PC Group: "A Statistical Package Software for Interactive Data Exploration and Model Building for Cluster Analysis-Tested," revised in 1990 and an updated 3.01 to Group PC Version, revised in 1992—available from Austin Data Management Associates, Post Office Box 4358, Austin, Texas 78765, (512) 320-0935.
- The Grouper, Classification Algorithm for RUG III using the MDS+, 1992.
- M^3PI Processor, Classification software for RUG III and M^3PI using the MDS+.
- MDS+ Analytic Database and Management Software, 1993.
- An RSM/STM Research Database, 1991, developed from the Resident Status Measure and Staff Time Measurement (RSM/STM) Study in seven States.
- Clinical Profiles of RMS/STM Study Population in EXCEL.
- RUG III Grouping Algorithm using MEDPAR, 1993.

92-027 Long-Term Care Program and Market Characteristics

Project No.:	18-C-90034/9
Period:	February 1992–December 1995
Funding:	$ 808,047
Award:	Cooperative Agreement
Principal Investigator:	Charlene Harrington, Ph.D.
Awardee:	University of California at San Francisco Office of Research Affairs 3333 California Street, Suite 11 San Francisco, CA 94143-0962
HCFA Project Officer:	Kay Lewandowski Division of Aging and Disability

Description: This project will collect data on and study the effects of nursing home and home health care characteristics and markets on Medicare and Medicaid services in the 50 States. Primary and secondary data for the 1990–94 period will be collected to update earlier data on previous studies for the 1978–89 period. Through surveys, data will be collected on licensed nursing home bed supply and occupancy rates, State certificate of need programs, State preadmission screening programs, and Medicaid nursing home and home health reimbursement. Data also are being collected on Medicaid waiver programs, Boren amendment litigation, provider characteristics, resident characteristics, and deficiencies of nursing homes. Analysis will provide detailed information on each State's current methodology for determining nursing home capital costs, the impact of proposed case-mix reimbursement on operating income, reimbursement methodology for freestanding subacute units, and Medicaid methodology used to reimburse for care provided in board and care homes, geriatric day care centers, and intermediate care facilities for the mentally retarded. A publicly accessible database will be developed that will provide a complete set of demonstration data for the period 1978–94.

Status: The first 3 years of the project have been completed. For the third year, an additional study collected information on State loan programs to identify those agencies making loans to health care facilities. The second State data book presenting data on long-term care program and market characteristics across the 50 States and the District of Columbia has been published: Health Care Financing Administration: *State Data Book on Long-Term Care Program and Market Characteristics, 1993.* Health Care Financing Extramural Report, HCFA Pub. No. 03366. U.S. Government Printing Office Washington, D.C. February 1995. It is currently anticipated that the final report, data set, and documentation will be available by December 1995.

89-034 **Long-Term Care Studies (Section 207)**

Project No.:	500-89-0047
Period:	September 1989–March 1996
Funding:	$ 3,790,000
Award:	Contract
Principal Investigator:	David Kennell
Awardee:	Lewin/VHI, Inc. 9302 Lee Highway Suite 500 Fairfax, VA 22031-1207
HCFA Project Officer:	Carolyn Rimes Division of Aging and Disability

Description: The purpose of this project is to conduct research related to the Health Care Financing Administration's Medicare and Medicaid programs in the area of long-term care (LTC) policy development. The awardee will focus primarily on four major areas:

- The financial characteristics of Medicare beneficiaries who receive or need LTC services.
- How the Medicare beneficiaries' characteristics affect their use of institutional and noninstitutional LTC services.
- How relatives of Medicare beneficiaries are affected financially and in other ways when beneficiaries require or receive LTC services.
- How the provision of LTC services may reduce expenditures for acute care health services.

Analyses will use existing LTC and other survey databases (e.g., the National Long-Term Care Surveys, the Longitudinal Study of Aging, the National Nursing Home Survey, the Medicare Current Beneficiary Survey, the Survey of Income and Program Participation, the National Medical Care Expenditure Survey). Medicare administrative records and other extant information also will be used. A number of focused analytic studies, policy reports, syntheses, and special studies are required under the contract.

Status: With the repeal of the Medicare Catastrophic Coverage Act of 1988, this project is no longer congressionally mandated. The following updates the status of each of the studies, indicating which reports are final and those that are in draft or pending final review. The final reports are as follows:

- "Analysis of Choice Processes in Capitated Plan Enrollment: Statistical Models for Evaluation of Voluntary Enrollment to Long-Term Care Demonstration Projects"
- "Analysis of Informal and Formal Care"
- "Analysis of Nonparticipation in the 2176 Program"
- "Analysis of Nursing Home Payment with Current Beneficiary Survey Data"
- "Analysis of Transitions in the Characteristics of the Long-Term Care Population"
- "Case Studies of Medicaid Estate Planning"
- "Catastrophic Costs of Long-Term Care"
- "Consumer Protection and Private Long-Term Care Insurance"
- "Elderly Wealth and Savings: Implications for Long-Term Care"
- "Examination of the Relation of Part A and Part B Medicare Expenditures"
- "Health Care Service Use and Expenditures of the Noninstitutionalized Population"
- "Key Issues for Private Long-Term Care Insurance"
- "Potential of Coordinated Care Targeted to Medicare Beneficiaries with Medicaid Coverage"
- "Regional Variation in Home Health Episode Length and Number of Visits Per Episode"
- "Simulations of Skilled Nursing Facility Payment Options"
- "State Responses to Medicaid Estate Planning"
- "Synthesis of Financing and Delivery of Long-Term Care for the Disabled Nonelderly"
- "Synthesis of Literature on Targeting to Reduce Hospital Use"
- "Synthesis of the Nursing Home Bed Supply"
- "Synthesis of Unmet Need for Long-Term-Care Services"

A conference to present selected findings was held in November 1994 and conference proceedings will be published by November 1995.

These are current studies:

- "Catastrophic Health Care Expenditures and Medicaid Coverage Among Community Residents"
- "Synthesis of Nursing Home Reimbursement Options"
- "The Effect of Geographic Variation on Medicare Capitation Rates for the Social HMO, PACE, CNO"
- "Issues in Long-Term-Care for the Disabled with Cognitive Impairment"
- "Synthesis of Literature on Effectiveness of Special Assistive Devices in Managing Functional Impairments"
- "Analysis of Nursing Home Payments with Medicare Current Beneficiary Survey (MCBS) Data"

- "Catastrophic Costs and Medicaid Spenddown"
- "Costs of Medicare SNF Therapy Services"
- "Longitudinal Health Care Use and Expenditures of Disabled"
- "Interrelationship of Medical Conditions in the Nursing Home Population"
- "An Analysis of Post-Acute Care and Therapy Services Using the HCFA Episode Database, Post-Acute Portion"

Final reports on these projects are expected to be completed in Winter 1996.

90-056 Long-Term Care Survey

Project No.:	HCFA-IA-9155
Period:	September 1990–February 1993
Funding:	
Award:	Interagency Agreement
Principal Investigator:	Richard Sussman
Awardee:	National Institute on Aging 9000 Rockville Pike Bethesda, MD 20892
HCFA Project Officer:	Carolyn Rimes Division of Aging and Disability

Description: The Office of the Assistant Secretary for Planning and Evaluation and the Health Care Financing Administration agree to transfer funds to the National Institute on Aging (NIA) to support an existing NIA grant to Duke University, Center for Demographic Studies. This grant is entitled Functional and Health Changes of the Elderly, 1982–89. The National Long-Term Care Survey (NLTCS) is a detailed household survey of persons 65 years of age or over who have some chronic functional impairment (90 days or more). The survey has been administered 3 times. The first, conducted in 1982, was devised as a cross-sectional survey. The second, conducted in 1984, added a longitudinal component to the sample design. The third, administered in 1989, used the cohorts from the previous surveys in addition to persons becoming 65 years of age to form a nationally representative sample of impaired elderly persons. To facilitate the use of the database, these tasks related to the 1982, 1984, and 1989 NLTCSs will be carried out under this agreement:

- File linkage over the entire period 1982–89.
- Derivation of new longitudinal sample weights.
- Linkage of Medicare administrative records.
- Improvement of coding by checking consistency of survey items.
- Improvement in survey documentation.
- Seminars and education.

Status: The public use version can be obtained from Michigan Archives by calling (313) 763-5011. The files are currently being matched with the HCFA administrative data to verify status (i.e., Medicare status and mortality).

94-079 Managed Care System for Disabled and Special Needs Children

Project No.:	18-P-90488/3
Period:	August 1994–August 1995
Funding:	$ 150,000
Award:	Grant
Principal Investigator:	Paul Offner
Awardee:	Government of the District of Columbia Commission on Health Care Finance 2100 Martin Luther King, Jr., Avenue, SE. Suite 302 Washington, DC 20020
HCFA Project Officer:	Phyllis A. Nagy Division of Aging and Disability

Description: The District of Columbia submitted a request for section 1115 waivers, which will permit it to implement a Medicaid-managed care initiative to serve approximately 3,000 children with disabilities and complex medical needs.

Status: A number of key issues in the waiver application required clarification. For example, it was felt that the District of Columbia needed to clearly identify cost projections, a sufficiently detailed reimbursement methodology, and an appropriate service delivery system. As a result, the District of Columbia was awarded grant funding to support a 12-month development phase beginning in August 1994. The purpose of this development phase was to provide an opportunity for the District of Columbia to obtain technical assistance and to resolve outstanding program design issues.

93-006 Managing Medical Care for Nursing Home Residents: United HealthCare Corporation, Inc. (Formerly, Managing Medical Care for Nursing Home Residents)

Project No.:	95-C-90174
Period:	December 1992–December 1998
Funding:	Waiver only
Award:	Cooperative Agreement
Principal Investigator:	Marcia Smith
Awardee:	United HealthCare Corporation, Inc. P.O. Box 1459 Minneapolis, MN 55440-8001
HCFA Project Officer:	Stefan N. Miller Division of Aging and Disability

Description: The objective of this demonstration is to study the effectiveness of managing acute care needs of nursing home residents by pairing physicians and geriatric nurse practitioners (GNP), who will function as primary medical caregivers and case managers. The major goals are to reduce medical complications and dislocation trauma resulting from

hospitalization and to save the expense of hospital care when patients could be managed safely in nursing homes with expanded services. The operating principal is EverCare, a subsidiary of United HealthCare Corporation, Inc. EverCare will receive a fixed capitated payment (based on a percentage of the adjusted average per capita cost) for all nursing home residents enrolled and will be at full financial risk for the cost of acute care services for the enrollees. Nine demonstration sites are expected to participate, with each site enrolling approximately 300 persons. GNPs will provide initial assessments of enrollees; make monthly visits; authorize clinic, outpatient, and hospital visits; and communicate with the patients' physicians, nursing facility staffs, and families. Physician incentive plans will be structured to offer a higher reimbursement rate for a nursing home visit and a lower reimbursement rate for services furnished in physicians' offices or in other settings. By increasing the intensity and availability of medical services, EverCare believes that this case management model will reduce total care costs, improve the quality of care received by participants through better coordination of appropriate acute care services, and improve the quality of life for and the level of satisfaction of enrollees and their families.

Status: Demonstration sites are currently operating in three cities: Atlanta, Baltimore, and Boston. Additional sites are expected on line in early 1996.

94-089 MAINE-NET: Medicaid- and Medicare-Managed Care for the Elderly and Physically Disabled in Maine

Project No.:	11-C-90437/1
Period:	September 1994–September 1997
Funding:	$ 944,940
Award:	Cooperative Agreement
Principal Investigator:	Christine Gianopoulos
Awardee:	Maine Department of Human Services Bureau of Medical Services State House Station No. 11 Augusta, ME 04333
HCFA Project Officer:	Kay Lewandowski Division of Aging and Disability

Description: This project is designed to demonstrate integrated models for the financing and delivery of managed health care and social services for Medicare and Medicaid elderly and physically disabled persons in Maine. The project seeks to promote the development of regional service delivery networks or health plans, particularly in rural areas of the State that would be responsible for the management, coordination, and integration of services, including multidisciplinary approaches to care planning and service delivery. The demonstration will provide a comprehensive package of primary, acute, and long-term care—institutional and noninstitutional-services—as part of a prepaid-capitated health plan for the target populations. The demonstration seeks to expand upon nursing home quality indicators developed in the Health Care Financing Administration sponsored multistate Case-Mix Demonstration Project and incorporate HCFA's quality assurance guidelines for managed care plans. In addition, the project will develop and use an activity of daily living-based case-mix adjustment for long-term care services in the construction of capitation payment rates, using the Resource Utilization Group III, Version classification system also developed in the multistate demonstration project. For services provided in boarding homes and in the community, two new case-mix methodologies will be developed for use by the demonstration.

Status: This project has completed its first year. During that period, a concept paper describing the State's health care environment and the challenges facing the proposed demonstration program was drafted. In addition, an analysis of the cost and use patterns of State elderly and disabled Medicaid recipients has been completed, and a similar analysis in year two will be made of Medicare expenditures for the same population. Focus groups have been convened, and the results have been summarized. The State currently anticipates beginning the waiver application process in August 1996.

94-087 Maximizing the Cost Effectiveness of Home Health Care: The Influence of Service Volume and Integration with Other Care Settings on Patient Outcomes

Project No.:	17-C-90435/8
Period:	September 1994–December 1997
Funding:	$ 1,231,466
Award:	Cooperative Agreement
Principal Investigator:	Peter W. Shaughnessy, Ph.D.
Awardee:	Center for Health Policy Research 1355 South Colorado Boulevard, Suite 706 Denver, CO 80222
HCFA Project Officer:	Elizabeth Mauser, Ph.D. Division of Aging and Disability

Description: Home health care (HHC) is the most rapidly growing component of the Medicare budget in recent years. The rapid growth in home health use has occurred despite limited evidence about the necessary volume of HHC to achieve optimal patient outcomes and whether it substitutes for more costly institutional care. Little is known about integrating HHC with care in other settings to reduce overall health care costs. The central hypotheses of this study are that volume-outcome relationships are present in HHC for common patient conditions, that upper and lower volume thresholds exist that define the range of services most

beneficial to patients, that and a strengthened physician role and better integration of HHC with other services during an episode of care can optimize patient outcomes while controlling costs. To test these hypotheses, a total of 3,600 patient records will be selected from a nationally representative sample of home health agencies. Trained data collectors at each agency will record patient health status and service information between HHC admission and discharge to assess patient outcomes and costs within the HHC episode. Long-term, self-reported outcomes will be assessed from telephone interview data at HHC admission and from 6-month followups. These primary data concerning patient status and outcomes will be combined with Medicare claims data over the episode of care to assess the relationship between service volume in HHC and in both patient outcomes and costs. Analysis of data relating to physician involvement and the sequence of use of other providers will address issues of integration with other services.

Status: Data collection will begin in 1996.

89-035 Medicare Alzheimer's Disease Demonstration: Amherst H. Wilder Foundation

Project No.:	95-P-60007
Period:	May 1989–November 1994
Funding:	Waiver only
Award:	Participation Agreement
Principal Investigator:	Robert Held
Awardee:	Amherst H. Wilder Foundation 919 La Fond Avenue St. Paul, MN 55104
HCFA Project Officer:	Dennis M. Nugent Division of Aging and Disability
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508) Omnibus Budget Reconciliation Act of 1993 (Public Law 103-66)

Description: The Medicare Alzheimer's Disease Demonstration was authorized by Congress to learn more about the health care needs of beneficiaries who have dementia. The purpose of the project was to determine the effectiveness, cost, and impact on health status and functioning of providing in-home and community-based services to beneficiaries with Alzheimer's disease and related disorders. Two models of care were studied under the demonstration. Both models included case management and a wide range of services, such as homemaker/personal care services, adult day care, companion services, caregiver education, and family counseling. The intensity of the case management provided to beneficiaries and their caregivers and the amount of demonstration service costs that could be paid for by Medicare each month differentiated the two models. Model A sites had a case manager to beneficiary ratio of 1:100 and a Medicare payment ceiling for demonstration services ranging from $355 to $430 a month. These caps reflected geographic cost variations. Model A sites were in Memphis, Tennessee; Portland, Oregon; Rochester, New York; and Urbana, Illinois. The case management ratio in the Model B sites was 1:30, and their monthly payment limits were between $580 and $699. Model B sites were located in Cincinnati, Ohio; Miami, Florida; Minneapolis, Minnesota; and Parkersburg, West Virginia.

Status: The operational phase of the demonstration began in December 1989 and ended in November 1994. The evaluation of the project is being conducted by the University of California at San Francisco. Data analysis is expected to be completed in April 1996.

89-036 Medicare Alzheimer's Disease Demonstration: Carle Clinic

Project No.:	95-P-60008
Period:	May 1989–November 1994
Funding:	Waiver only
Award:	Participation Agreement
Principal Investigator:	Cheryl Schraeder, Ph.D.
Awardee:	Carle Clinic Association 307 East Oak, Suite 3 P.O. Box 718 Mahomet, IL 61853
HCFA Project Officer:	Dennis M. Nugent Division of Aging and Disability
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508) Omnibus Budget Reconciliation Act of 1993 (Public Law 103-66)

Description: The Medicare Alzheimer's Disease Demonstration was authorized by Congress to learn more about the health care needs of beneficiaries who have dementia. The purpose of the project was to determine the effectiveness, cost, and impact on health status and functioning of providing in-home and community-based services to beneficiaries with Alzheimer's disease and related disorders. Two models of care were studied under the demonstration. Both models included case management and a wide range of services, such as homemaker/personal care services, adult day care, companion services, caregiver education, and family counseling. The intensity of the case management provided to beneficiaries and their caregivers and the amount of demonstration service costs that could be

paid for by Medicare each month differentiated the two models. Model A sites had a case manager to beneficiary ratio of 1:100 and a Medicare payment ceiling for demonstration services ranging from $355 to $430 a month. These caps reflected geographic cost variations. Model A sites were in Memphis, Tennessee; Portland, Oregon; Rochester, New York; and Urbana, Illinois. The case management ratio in the Model B sites was 1:30, and their monthly payment limits were between $580 and $699. Model B sites were located in Cincinnati, Ohio; Miami, Florida; Minneapolis, Minnesota; and Parkersburg, West Virginia.

Status: The operational phase of the demonstration began in December 1989 and ended in November 1994. The evaluation of the project is being conducted by the University of California at San Francisco. Data analysis is expected to be completed in April 1996.

89-037 **Medicare Alzheimer's Disease Demonstration: Cincinnati Area Senior Services, Inc.**

Project No.:	95-P-60002
Period:	May 1989–November 1994
Funding:	Waiver only
Award:	Participation Agreement
Principal Investigator:	Beth Patterson
Awardee:	Cincinnati Area Senior Services, Inc. 644 Linn Street, Suite 1017 Cincinnati, OH 45203
HCFA Project Officer:	Dennis M. Nugent Division of Aging and Disability
Mandates:	Omnibus Budget Reconcilliation Act of 1986 (Public Law 99-509) Omnibus Budget Reconcilliation Act of 1990 (Public Law 101-508) Omnibus Budget Reconcilliation Act of 1993 (Public Law 103-66)

Description: The Medicare Alzheimer's Disease Demonstration was authorized by Congress to learn more about the health care needs of beneficiaries who have dementia. The purpose of the project was to determine the effectiveness, cost, and impact on health status and functioning of providing in-home and community-based services to beneficiaries with Alzheimer's disease and related disorders. Two models of care were studied under the demonstration. Both models included case management and a wide range of services, such as homemaker/personal care services, adult day care, companion services, caregiver education and family counseling. The intensity of the case management provided to beneficiaries and their caregivers and the amount of demonstration service costs that could be paid for by Medicare each month differentiated the two models. Model A sites had a case manager to beneficiary ratio of 1:100 and a Medicare payment ceiling of demonstration services ranging from $335 to $430 a month. These caps reflected geographic cost variations. Model A sites were in Memphis, Tennessee; Portland, Oregon; Rochester, New York; and Urbana, Illinois. The case management ratio in the Model B sites was 1:30 and their monthly payment limits were between $580 and $699. Model B sites were located in Cinncinnati, Ohio; Miami, Florida; Minneapolis, Minnesota; and Parkersburg, West Virginia.

Status: The operational phase of the demonstration began in December 1989 and ended in November 1994. The evaluation of the project is being conducted at the University of California at San Francisco. Data analysis is expected to be completed in April 1996.

89-038 **Medicare Alzheimer's Disease Demonstration: Good Samaritan Hospital and Medical Center**

Project No.:	95-P-60001
Period:	May 1989–November 1994
Funding:	Waiver only
Award:	Participation Agreement
Principal Investigator:	Elizabeth Baxter
Awardee:	Good Samaritan Hospital and Medical Center 1015 Northwest 22nd Avenue Portland, OR 97210
HCFA Project Officer:	Dennis M. Nugent Division of Aging and Disability
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508) Omnibus Budget Reconciliation Act of 1993 (Public Law 103-66)

Description: The Medicare Alzheimer's Disease Demonstration was authorized by Congress to learn more about the health care needs of beneficiaries who have dementia. The purpose of the project was to determine the effectiveness, cost, and impact on health status and functioning of providing in-home and community-based services to beneficiaries with Alzheimer's disease and related disorders. Two models of care were studied under the demonstration. Both models included case management and a wide range of services, such as homemaker/personal care services, adult day care, companion services, caregiver education, and family counseling. The intensity of the case management provided to beneficiaries and their caregivers and the amount of demonstration service costs that could be paid for by Medicare each month differentiated the two models. Model A sites had a case manager to beneficiary ratio of 1:100 and a Medicare payment ceiling for demonstration services ranging from $355 to $430 a month.

These caps reflected geographic cost variations. Model A sites were in Memphis, Tennessee; Portland, Oregon; Rochester, New York; and Urbana, Illinois. The case management ratio in the Model B sites was 1:30, and their monthly payment limits were between $580 and $699. Model B sites were located in Cincinnati, Ohio; Miami, Florida; Minneapolis, Minnesota; and Parkersburg, West Virginia.

Status: The operational phase of the demonstration began in December 1989 and ended in November 1994. The evaluation of the project is being conducted by the University of California at San Francisco. Data analysis is expected to be completed in April 1996.

89-039 Medicare Alzheimer's Disease Demonstration: Miami Jewish Home Hospital for the Aged

Project No.:	95-P-60005
Period:	May 1989–November 1994
Funding:	Waiver only
Award:	Participation Agreement
Principal Investigator:	Betsy Pegelow
Awardee:	Miami Jewish Home and Hospital for the Aged 151 Northeast 52nd Street Miami, FL 33137
HCFA Project Officer:	Dennis M. Nugent Division of Aging and Disability
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508) Omnibus Budget Reconciliation Act of 1993 (Public Law 103-66)

Description: The Medicare Alzheimer's Disease Demonstration was authorized by Congress to learn more about the health care needs of beneficiaries who have dementia. The purpose of the project was to determine the effectiveness, cost, and impact on health status and functioning of providing in-home and community-based services to beneficiaries with Alzheimer's disease and related disorders. Two models of care were studied under the demonstration. Both models included case management and a wide range of services, such as homemaker/personal care services, adult day care, companion services, caregiver education, and family counseling. The intensity of the case management provided to beneficiaries and their caregivers and the amount of demonstration service costs that could be paid for by Medicare each month differentiated the two models. Model A sites had a case manager to beneficiary ratio of 1:100 and a Medicare payment ceiling for demonstration services ranging from $355 to $430 a month. These caps reflected geographic cost variations. Model A sites were in Memphis, Tennessee; Portland, Oregon; Rochester, New York; and Urbana, Illinois. The case management ratio in the Model B sites was 1:30, and their monthly payment limits were between $580 and $699. Model B sites were located in Cincinnati, Ohio; Miami, Florida; Minneapolis, Minnesota; and Parkersburg, West Virginia.

Status: The operational phase of the demonstration began in December 1989 and ended in November 1994. The evaluation of the project is being conducted by the University of California at San Francisco. Data analysis is expected to be completed in April 1996.

89-040 Medicare Alzheimer's Disease Demonstration: Monroe County Longterm Care Program, Inc.

Project No.:	95-P-60006
Period:	May 1989–November 1994
Funding:	Waiver only
Award:	Participation Agreement
Principal Investigator:	Gerald Eggert, Ph.D.
Awardee:	Monroe County Longterm Care Program, Inc. 349 West Commercial Street, Suite 2250 East Rochester, NY 14445
HCFA Project Officer:	Dennis M. Nugent Division of Aging and Disability
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508) Omnibus Budget Reconciliation Act of 1993 (Public Law 103-66)

Description: The Medicare Alzheimer's Disease Demonstration was authorized by Congress to learn more about the health care needs of beneficiaries who have dementia. The purpose of the project was to determine the effectiveness, cost, and impact on health status and functioning of providing in-home and community-based services to beneficiaries with Alzheimer's disease and related disorders. Two models of care were studied under the demonstration. Both models included case management and a wide range of services, such as homemaker/personal care services, adult day care, companion services, caregiver education, and family counseling. The intensity of the case management provided to beneficiaries and their caregivers and the amount of demonstration service costs that could be paid for by Medicare each month differentiated the two models. Model A sites had a case manager to beneficiary ratio of 1:100 and a Medicare payment ceiling for demonstration services ranging from $355 to $430 a month. These caps reflected geographic cost variations. Model A

sites were in Memphis, Tennessee; Portland, Oregon; Rochester, New York; and Urbana, Illinois. The case management ratio in the Model B sites was 1:30, and their monthly payment limits were between $580 and $699. Model B sites were located in Cincinnati, Ohio; Miami, Florida; Minneapolis, Minnesota; and Parkersburg, West Virginia.

Status: The operational phase of the demonstration began in December 1989 and ended in November 1994. The evaluation of the project is being conducted by the University of California at San Francisco. Data analysis is expected to be completed in April 1996.

89-041 Medicare Alzheimer's Disease Demonstration: Northeast Alzheimer's Consortium

Project No.:	95-P-60003
Period:	May 1989–November 1994
Funding:	Waiver only
Award:	Participation Agreement
Principal Investigator:	Glen Gunnels
Awardee:	Northeast Alzheimer's Consortium 1330 Sycamore View, Suite 2 Memphis, TN 38314
HCFA Project Officer:	Dennis M. Nugent Division of Aging and Disability
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508) Omnibus Budget Reconciliation Act of 1993 (Public Law 103-66)

Description: The Medicare Alzheimer's Disease Demonstration was authorized by Congress to learn more about the health care needs of beneficiaries who have dementia. The purpose of the project was to determine the effectiveness, cost, and impact on health status and functioning of providing in-home and community-based services to beneficiaries with Alzheimer's disease and related disorders. Two models of care were studied under the demonstration. Both models included case management and a wide range of services, such as homemaker/personal care services, adult day care, companion services, caregiver education, and family counseling. The intensity of the case management provided to beneficiaries and their caregivers and the amount of demonstration service costs that could be paid for by Medicare each month differentiated the two models. Model A sites had a case manager to beneficiary ratio of 1:100 and a Medicare payment ceiling for demonstration services ranging from $355 to $430 a month. These caps reflected geographic cost variations. Model A sites were in Memphis, Tennessee; Portland, Oregon; Rochester, New York; and Urbana, Illinois. The case management ratio in the Model B sites was 1:30, and their monthly payment limits were between $580 and $699. Model B sites were located in Cincinnati, Ohio; Miami, Florida; Minneapolis, Minnesota; and Parkersburg, West Virginia.

Status: The operational phase of the demonstration began in December 1989 and ended in November 1994. The evaluation of the project is being conducted by the University of California at San Francisco. Data analysis is expected to be completed in April 1996.

89-042 Medicare Alzheimer's Disease Demonstration: Wood County Senior Citizens Association, Inc.

Project No.:	95-P-60004
Period:	May 1989–November 1994
Funding:	Waiver only
Award:	Participation Agreement
Principal Investigator:	Karen Leachman
Awardee:	Wood County Senior Citizens Association, Inc. 925 Market Street Parkersburg, WV 26101
HCFA Project Officer:	Dennis M. Nugent Division of Aging and Disability
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508) Omnibus Budget Reconciliation Act of 1993 (Public Law 103-66)

Description: The Medicare Alzheimer's Disease Demonstration was authorized by Congress to learn more about the health care needs of beneficiaries who have dementia. The purpose of the project was to determine the effectiveness, cost, and impact on health status and functioning of providing in-home and community-based services to beneficiaries with Alzheimer's disease and related disorders. Two models of care were studied under the demonstration. Both models included case management and a wide range of services, such as homemaker/personal care services, adult day care, companion services, caregiver education, and family counseling. The intensity of the case management provided to beneficiaries and their caregivers and the amount of demonstration service costs that could be paid for by Medicare each month differentiated the two models. Model A sites had a case manager to beneficiary ratio of 1:100 and a Medicare payment ceiling for demonstration services ranging from $355 to $430 a month. These caps reflected geographic cost variations. Model A

sites were in Memphis, Tennessee; Portland, Oregon; Rochester, New York; and Urbana, Illinois. The case management ratio in the Model B sites was 1:30, and their monthly payment limits were between $580 and $699. Model B sites were located in Cincinnati, Ohio; Miami, Florida; Minneapolis, Minnesota; and Parkersburg, West Virginia.

Status: The operational phase of the demonstration began in December 1989 and ended in November 1994. The evaluation of the project is being conducted by the University of California at San Francisco. Data analysis is expected to be completed in April 1996.

89-054 **Multistate Nursing Home Case-Mix and Quality Demonstration: Kansas** (Formerly, The Multistate Nursing Home Case-Mix and Quality Demonstration)

Project No.:	11-C-99366/7
Period:	June 1989–December 1998
Funding:	$ 1,544,755
Award:	Cooperative Agreement
Principal Investigator:	Elaine Wells
Awardee:	Kansas Department of Social and Rehabilitative Services Adult Services Commission—Adult Care Home Program West Hall 300 Oakley Street, SW. Topeka, KS 66606
HCFA Project Officer:	Elizabeth S. Cornelius Division of Payment Systems

Description: This project builds on past and current initiatives with nursing home case-mix payment and quality assurance. The 6-year demonstration will design, implement, and evaluate a combined Medicare and Medicaid nursing home resident classification and payment system in Kansas, Maine, Mississippi, and South Dakota. The purpose of the demonstration is to test a resident information system with variables for classifying residents into homogeneous resource use groups for equitable payment and for quality monitoring of outcomes adjusted for case mix. The new minimum data set plus (MDS+) for resident assessment will be used for resident care-planning, payment classification, and quality-monitoring systems. The project consists of three phases: systems development and design, systems implementation and monitoring, and evaluation.

Status: The project has conducted a field test of the minimum data set on 6,660 nursing home residents. The average direct care staff time across the States is 115 minutes per day per resident. A new patient classification system and a Multistate Medicare/Medicaid Payment Index containing 44 groups has been created. Kansas uses all 44 groups and the nursing plus therapy index in its Medicaid system. The States implemented the MDS+ in fall 1990 with the approval of the Health Standards and Quality Bureau. The States have collected and reviewed over 2 million MDS+ documents on over 400,000 different residents assessed between September 1990 and July 1995. In developing the payment systems, facility cost reports and resident characteristic data were analyzed to determine the case mix of residents and patterns of service use. Kansas implemented its Medicaid payment system in January 1994. The Medicare case-mix-adjusted payment system was implemented in August 1995. The quality monitoring information system has been pilot tested, and 30 quality indicators have been developed for facility-level and resident-level quality monitoring. The quality-monitoring system will be implemented statewide on an area-by-area basis in Fall 1995.

89-055 **Multistate Nursing Home Case-Mix and Quality Demonstration: Maine** (Formerly, The Multistate Nursing Home Case-Mix and Quality Demonstration)

Project No.:	11-C-99363/1
Period:	June 1989–December 1998
Funding:	$ 1,290,838
Award:	Cooperative Agreement
Principal Investigator:	Andrew Coburn, Ph.D.
Awardee:	Maine Department of Human Services Bureau of Medical Services State House Station No. 11 Augusta, ME 04333
HCFA Project Officer:	Elizabeth S. Cornelius Division of Payment Systems

Description: This project builds on past and current initiatives with nursing home case-mix payment and quality assurance. The 6-year demonstration will design, implement, and evaluate a combined Medicare and Medicaid nursing home resident classification and payment system in Kansas, Maine, Mississippi, and South Dakota. The purpose of the demonstration is to test a resident information system with variables for classifying residents into homogeneous resource use groups for equitable payment and for quality monitoring of outcomes adjusted for case mix. The new minimum data set plus (MDS+) for resident assessment will be used for resident care-planning, payment classification, and quality-monitoring systems. The project consists of three phases: systems development and design, systems implementation and monitoring, and evaluation.

Status: The project has conducted a field test of the minimum data set on 6,660 nursing home residents. The average direct care staff time across the States is 115 minutes per day per resident. A new patient classification system and a Multistate Medicare/Medicaid

Payment Index containing 44 groups has been created. Maine uses all 44 groups and the nursing index in its Medicaid system. The States implemented the MDS+ in fall 1990 with the approval of the Health Standards and Quality Bureau. The States have collected and reviewed over 2 million MDS+ documents on over 400,000 different residents assessed between September 1990 and July 1995. In developing the payment systems, resident characteristic data and facility cost reports were analyzed to determine the case mix of residents and patterns of service utilization. Maine began implementing its Medicaid payment system on October 1, 1993. The Medicare case-mix-adjusted payment system was implemented in Maine in July 1995. The quality monitoring information system has been pilot tested, and 30 quality indicators have been developed for facility-level and resident-level quality monitoring.

89-056 **Multistate Nursing Home Case-Mix and Quality Demonstration: Mississippi** (Formerly, The Multistate Nursing Home Case-Mix and Quality Demonstration)

Project No.:	11-C-99362/4
Period:	June 1989–December 1995
Funding:	$ 1,572,289
Award:	Cooperative Agreement
Principal Investigator:	Jamie L. Collier
Awardee:	Office of Governor Division of Medicaid Robert E. Lee Building, Suite 801 239 North Lamar Street Jackson, MS 39201
HCFA Project Officer:	Elizabeth S. Cornelius Division of Payment Systems

Description: This project builds on past and current initiatives with nursing home case-mix payment and quality assurance. The 6-year demonstration will design, implement, and evaluate a combined Medicare and Medicaid nursing home resident classification and payment system in Kansas, Maine, Mississippi, and South Dakota. The purpose of the demonstration is to test a resident information system with variables for classifying residents into homogeneous resource use groups for equitable payment and for quality monitoring of outcomes adjusted for case mix. The new minimum data set plus (MDS+) for resident assessment will be used for resident care-planning, payment classification, and quality-monitoring systems. The project consists of three phases: systems development and design, systems implementation and monitoring, and evaluation.

Status: The project has conducted a field test of the minimum data set on 6,660 nursing home residents. The average direct care staff time across the States is 115 minutes per day per resident. A new patient classification system and a Multistate Medicare/Medicaid Payment Index containing 44 groups has been created. A 35-group variation was approved in January 1993 for the Medicaid portion in Mississippi and South Dakota. The variation collapses the 12 rehabilitation groups into 3 groups for Medicaid purposes. The States implemented the MDS+ in fall 1990 with the approval of the Health Standards and Quality Bureau. The States have collected and reviewed over 2 million MDS+ documents on over 400,000 different residents assessed between September 1990 and July 1995. In developing the payment systems, the resident characteristic data and facility cost reports have been analyzed to determine the case mix of residents and patterns of service utilization. In July 1993, Mississippi implemented its Medicaid case-mix systems statewide. The Medicare case-mix-adjusted payment system will be implemented in late 1995. The quality monitoring information system has been pilot tested, and 30 quality indicators have been developed for facility-level and resident-level quality monitoring.

89-057 **Multistate Nursing Home Case-Mix and Quality Demonstration: South Dakota** (Formerly, The Multistate Nursing Home Case-Mix and Quality Demonstration)

Project No.:	11-C-99367/8
Period:	June 1989–December 1998
Funding:	$ 1,320,290
Award:	Cooperative Agreement
Principal Investigator:	Carol Job, R.N.
Awardee:	South Dakota Department of Social Services Office of Adult Services and Aging 700 Governors' Drive Pierre, SD 57501
HCFA Project Officer:	Elizabeth S. Cornelius Division of Payment Systems

Description: This project builds on past and current initiatives with nursing home case-mix payment and quality assurance. The 6-year demonstration will design, implement, and evaluate a combined Medicare and Medicaid nursing home resident classification and payment system in Kansas, Maine, Mississippi, and South Dakota. The purpose of the demonstration is to test a resident information system with variables for classifying residents into homogeneous resource use groups for equitable payment and for quality monitoring of outcomes adjusted for case mix. The new minimum data set plus (MDS+) for resident assessment will be used for resident care-planning, payment classification, and quality-monitoring systems. The project consists of three phases: systems development and design, systems implementation and monitoring, and evaluation.

Status: The project has conducted a field test of the minimum data set on 6,660 nursing home residents. The average direct care staff time across the States is 115 minutes per day per

resident. A new patient classification system and a Multistate Medicare/Medicaid Payment Index containing 44 groups has been created. A 35-group variation was approved in January 1993 for the Medicaid portion in Mississippi and South Dakota. The variation collapses the 12 rehabilitation groups into 3 groups for Medicaid purposes. The States implemented the MDS+ in fall 1990 with the approval of the Health Standards and Quality Bureau. The States have collected and reviewed over 2 million MDS+ documents on over 400,000 different residents assessed between September 1990 and July 1995. In developing the payment systems, the resident characteristic data and facility cost reports were analyzed to determine the case mix of residents and patterns of service utilization. In July 1993, South Dakota implemented its Medicaid case-mix systems statewide. The Medicare case-mix-adjusted payment system will be implemented in late 1995. The quality monitoring information system has been pilot tested, and 30 quality indicators have been developed for facility-level and resident-level quality monitoring.

93-048 **National Health Interview Survey Disability Supplement: 1994–95** (Formerly, A 1994/1995 National Health Interview Survey Disability Supplement)

Project No.:	HCFA-IA-9362
Period:	June 1993–June 1994
Award:	Interagency Agreement
Principal Investigator:	Owen Thornberry
Awardee:	Centers for Disease Control National Center for Health Statistics 6325 Belcrest Road, Room 850 Hyattsville, MD 20782
HCFA Project Officer:	Elizabeth Mauser, Ph.D. Division of Aging and Disability

Description: The Health Care Financing Administration's (HCFA's) transfer of funds to the National Center for Health Statistics is in support of the implementation of the 1994/1995 disability survey as a supplement to the National Health Interview Survey. Although HCFA provides extensive support for the disabled through the Medicare and Medicaid programs, very little is known about this population. The National Health Interview Survey Disability Supplement (NHISDS) will be the first survey on the disabled in 15 years. The NHISDS will be conducted during calendar years 1994 and 1995, with approximately 250,000 people of the 96,000 sampled households. The survey will consist of two phases:

- Phase I will screen the relevant populations and will collect basic descriptive information.
- Phase II will obtain information on all household members who experience limitations caused by a health condition.

Data from Phase I will be used to make estimates of the prevalence of disability and to determine eligibility for Phase II questionnaires. In Phase II, separate questionnaires will be given to adult and child respondents. This survey will be the first source of information to determine the size, characteristics, service use, and out-of-pocket costs for individuals with mental retardation and related conditions. The survey of children will provide information on the number, characteristics, severity, and effects on families of children with disabilities. This survey will collect information on income and assets, along with basic disability information, to better understand the characteristics of actual and potential Supplemental Security Income recipients. The information gathered from the NHISDS will be crucial for addressing a broad number of HCFA policy concerns affecting persons with disabilities.

Status: Questionnaires for the disability supplement have been revised. Phase I interviews began in January 1994 and Phase II adult and children interviews began during Summer 1994.

94-114 **National Minority Historically Black Colleges and Universities Health Education Initiative**

Project No.:	HCFA-IA-4105
Period:	September 1994–September 1996
Funding:	$ 200,000
Award:	Interagency Agreement
Principal Investigator:	Dorothy G. Moore
Awardee:	National Association for Equal Opportunity in Higher Education Black Higher Education Center Lovejoy Building 400 12th Street, NE. Washington, DC 20002
HCFA Project Officer:	Samuel L. Brown Division of Aging and Disability

Description: The purpose of this inter-agency agreement is for the Health Care Financing Administration (HCFA) to provide financial support to the Centers for Disease Control (CDC) in support of an existing CDC cooperative agreement with the National Association for Equal Opportunity (NAFEO) in Higher Education. This endeavor includes 117 historically black colleges and universities (HBCU) participating in the implementation of an human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS) education program. This effort will focus on implementation of a model program to provide HIV/AIDS education, prevention, and information on eligibility criteria for the Medicaid program for students and faculty of the 117 HBCUs. The objective is to integrate prevention activities into curricular and noncurricular programs. In addition, the HBCUs shall, in conjunction with NAFEO,

develop a student pamphlet on State-level Medicaid eligibility criteria and coverage policy for minority persons with HIV/AIDS. This pamphlet should explain the criteria for defining HIV/AIDS disability for purposes of establishing eligibility for participation in the Medicaid program for each HBCU's home State and for identifying the State agency that is responsible for making disability determinations. The pamphlet also should explain the mandatory and optional services available to Medicaid eligible minority persons with AIDS. A final report prepared by NAFEO will synthesize and integrate the results of the Medicaid eligibility criteria and coverage policies of each State for every participating HBCU. This report shall include an issue paper on the topic of health systems reform as it might affect Medicaid eligibility for persons with AIDS. Also included will be clarification and specification of the major issues or questions regarding health care system reform, financing, delivery, and quality of care among minority persons with AIDS; a review of the published literature on the subject; a description of any additional barriers to health care services faced by black persons or other minority people with AIDS; and the development of alternative courses of action in the context of the objective of State-level health care system reform and an assessment of the feasibility for implementating the proposed alternatives.

Status: In Spring 1995, a panel session on HIV/AIDS/STV prevention was held in Washington, D.C., at NEFEO's annual conference for HBCU members. This panel featured several speakers from HCFA. The grantee continues to collaborate with participating HBCUs to develop and implement HIV/AIDS/STD awareness and education programs. A report on this project is expected in Fall 1996.

94-113 National Recurring Data Set Project: Ongoing National State-by-State Data Collection and Policy/Impact Analysis on Residential Services for Persons with Developmental Disabilities

Project No.:	HCFA-IA-9485
Period:	September 1995–September 1996
Funding:	$ 25,000
Award:	Interagency Agreement
Principal Investigator:	Charlie Lakin, Ph.D.
Awardee:	University of Minnesota Institute of Community Integration 150 Pillsbury Drive, SE. Minneapolis, MN 55455
HCFA Project Officer:	Samuel L. Brown Division of Aging and Disability

Description: This interagency agreement will support secondary data analyses and the production of a report that describes and updates the status of persons with mental retardation and related conditions (MR/RC) in institutional care facilities for the mentally retarded (ICF-MRs), Medicaid waiver programs, and nursing homes funded under the Medicaid program to assist in the evaluation of Medicaid services for persons with MR/RCs and to point out areas in need of reform. The report will include the following:

- Background description of the key Medicaid programs of interest.
- State-by-state and national statistics on ICF-MRs, Medicaid home and community-based services, and nursing home use.
- Description of the characteristics of ICF-MRs and their residents, with comparative statistics for noncertified facilities.

Status: The University of Minnesota continues to collect data to produce its annual report on the status of the Medicaid programs that serve the developmentally disabled.

90-019 New York Case-Mix Payment and Quality Demonstration

Project No.:	95-C-99540/2
Period:	May 1990–December 1998
Funding:	$ 981,718
Award:	Cooperative Agreement
Principal Investigator:	Steven C. Anderman
Awardee:	New York State Department of Health Empire State Plaza Room 1683, Corning Tower Albany, NY 12237
HCFA Project Officer:	Elizabeth S. Cornelius Division of Payment Systems

Description: New York State will participate in the multistate Nursing Home Case-Mix and Quality (NHCMQ) Demonstration. The objective of the demonstration is to test the feasibility and cost effectiveness of a case-mix payment system for nursing facility services under the Medicare and Medicaid programs that are based on a common patient classification system. The addition of New York State enhances the Health Care Financing Administration's ability to project the results of the demonstration on a national basis. New York represents a heavily regulated, northern, industrialized area with larger, high-cost nursing facilities that are medically sophisticated and highly skilled. Sixteen percent of the national Medicare skilled nursing facility (SNF) days are incurred in New York State. New York is uniquely suited for inclusion because it already has implemented a complementary system for its Medicaid nursing facility payment program.

Status: In early 1991, the project staff completed the minimum data set field test in 25 facilities on 993 residents. These data have been added to the database and analyzed to develop the new NHCMQ Medicare/Medicaid classification system. The inclusion of the New York State data has resulted in the addition of a very high rehabilitation group to the upper end of the classification. The State has implemented the minimum data set plus (MDS+) statewide as its resident assessment instrument. In November 1992, the New York State began receiving the information monthly from all facilities; by July 1, 1995, it had received a total of 1,152,000 assessments. In developing the Medicare payment system the 1990 Medicare cost reports were used, as well as the MDS+ data and the Medicare provider analysis and review file. The Medicare case-mix-adjusted payment system was implemented July 1, 1995, in New York. By fall 1995, there were over 250 SNFs participating in the SNF demonstration.

84-008 On Lok's Risk-Based Community Care Organization for Dependent Adults: California Department of Health Services (Formerly, On Lok's Risk-Based Community Care Organization for Dependent Adults)

Project No.:	11-P-98334
Period:	November 1983–Indefinite
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Louise Nava
Awardee:	California Department of Health Services 714/744 P Street P.O. Box 942732 San Francisco, CA 94234-7320
HCFA Project Officer:	Stefan N. Miller Division of Aging and Disability
Mandates:	Social Security Amendments of 1983 (Public Law 98-21) Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272)

Description: As mandated by sections 603(c)(1) and (2) of Public Law 98-21, the Health Care Financing Administration granted Medicare waivers to On Lok Senior Health Services and Medicaid waivers to the California Department of Health Services. Together, these waivers permitted On Lok to implement an at-risk, capitated payment demonstration in which more than 300 frail elderly persons, certified by the California Department of Health Services for institutionalization in a skilled nursing facility, are provided a comprehensive array of health and health-related services in the community. The current demonstration maintains On Lok's comprehensive community-based program but has modified its financial base and reimbursement mechanism. All services are paid for by a predetermined capitated rate from both the Medicare and Medicaid (Medi-Cal) programs. The Medicare rate is based on the average per capita cost for the San Francisco County Medicare population. The Medi-Cal rate is based on the State's computation of current costs for similar Medi-Cal recipients, using the formula for prepaid health plans. Individual participants may be required to make copayments, spend down income, or divest assets, based on their financial status and eligibility for either or both programs. On Lok has accepted total risk beyond the capitated rates of both Medicare and Medi-Cal, with the exception of the Medicare payment for end stage renal disease. The demonstration provides service funding only under the waivers. Research and development activities are funded through private foundations.

Status: Section 9220 of Public Law 99-272 has extended On Lok's Risk-Based Community Care Organization for Dependent Adults indefinitely, subject to the terms and conditions in effect as of July 1, 1985, with the exception of the requirements relating to data collection and evaluation.

90-060 Nurse Practitioner/Physician Assistant Aggregate Visit Demonstration

Project No.:	95-C-99625/1
Period:	September 1990–September 1993
Funding:	$ 130,538
Award:	Cooperative Agreement
Principal Investigator:	Jeffrey L. Kang
Awardee:	The Urban Medical Group 545D Centre Street Jamaica Plain, MA 02130
HCFA Project Officer:	Phyllis A. Nagy Division of Aging and Disability
Mandate:	Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239)

Description: Under section 6114(e) of Public Law 101-239, the Medicare program provides Part B coverage to nursing home residents for medical visits rendered by nurse practitioners who are members of a physician/physician assistant/nurse practitioner team. Under this legislation, the number of visits supplied to any nursing home patient is limited to an average of 1.5 visits per month. Section 6114(e) mandates a demonstration project under which the visit limitation would be applied on an average basis over the aggregate total of residents receiving services from members of the provider team. A preliminary Massachusetts demonstration project, Case-Managed Medical Care for Nursing Home Patients, used nurse practitioners and physician assistants to provide visits to nursing home patients. This project ended on September 30, 1990. Many of the original Massachusetts demonstration sites also participated in this second demonstration project.

Status: This project was conducted in two phases. The first (primarily involving planning and development activities) was completed in March 1992. The second, which included the actual implementation and operation, was completed in March 1993. Although negotiations with the Medicare carrier, Massachusetts Blue Cross and Blue Shield, were concluded during the first phase, the grantee experienced a great deal of difficulty in securing usable/clean data. A 6-month-no-cost extension of the grant (until September 29, 1993) was provided. Massachusetts Blue Cross and Blue Shield was unable to provide corrected data until Spring 1994. The final report has been received and is currently under review.

84-001 On Lok's Risk-Based Community Care Organization for Dependent Adults: On Lok Senior Health Services (Formerly, On Lok's Risk-Based Community Care Organization for Dependent Adults)

Project No.:	95-P-98246
Period:	November 1983–Indefinite
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Sue Wong
Awardee:	On Lok Senior Health Services 1333 Bush Street San Francisco, CA 94109
HCFA Project Officer:	Stefan N. Miller Division of Aging and Disability
Mandates:	Social Security Amendments of 1983 (Public Law 98-21) Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272)

Description: As mandated by sections 603(c)(1) and (2) of Public Law 98-21, the Health Care Financing Administration granted Medicare waivers to On Lok Senior Health Services and Medicaid waivers to the California Department of Health Services. Together, these waivers permitted On Lok to implement an at-risk, capitated payment demonstration in which more than 300 frail elderly persons, certified by the California Department of Health Services for institutionalization in a skilled nursing facility, are provided a comprehensive array of health and health-related services in the community. The current demonstration maintains On Lok's comprehensive community-based program but has modified its financial base and reimbursement mechanism. All services are paid for by a predetermined capitated rate from both the Medicare and Medicaid (Medi-Cal) programs. The Medicare rate is based on the average per capita cost for the San Francisco county Medicare population. The Medi-Cal rate is based on the State's computation of current costs for similar Medi-Cal recipients, using the formula for prepaid health plans. Individual participants may be required to make copayments, spend down income, or divest assets based on their financial status and eligibility for either or both programs. On Lok has accepted total risk beyond the capitated rates of both Medicare and Medi-Cal, with the exception of the Medicare payment for end stage renal disease. The demonstration provides service funding only under the waivers. Research and development activities are funded through private foundations.

Status: Section 9220 of Public Law 99-272 has extended On Lok's Risk-Based Community Care Organization for Dependent Adults indefinitely, subject to the terms and conditions in effect as of July 1, 1985, with the exception of the requirements relating to data collection and evaluation. On Lok is continuing to develop collaborative projects with other organizations in the San Francisco Bay area. A pilot agreement with the Institute on Aging was completed. Both organizations are continuing to explore additional cooperative projects.

95-076 Phase II Implementation of the Home Health Agency (HHA) Prospective Payment Demonstration

Project No.:	500-95-0011
Period:	September 1995–September 1999
Funding:	$1,811,184
Award:	Contract
Principal Investigator:	Henry Goldberg
Awardee:	Abt Associates, Inc. 55 Wheeler Street Cambridge, MA 02138
HCFA Project Officer:	J. Donald Sherwood Division of Payment Systems
Mandate:	Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203)

Description: This contract implements and monitors Phase II of the Home Health Agency (HHA) Prospective Payment Demonstration. Under Phase II, a single payment per episode approach will be tested for Medicare-covered home health care. HHA participation is voluntary. It is expected that approximately 100 agencies in California, Florida, Illinois, Massachusetts, and Texas will participate in the demonstration. HHAs that agree to participate will be randomly assigned to either the prospective payment method or a control group that continues to be reimbursed in accordance with the current Medicare retrospective cost system. HHAs will participate in the demonstration for 3 years.

Status: Phase II recruitment began in fall 1994 under a previous contract with Abt Associates, Inc. The first HHAs to participate began receiving per episode payments in June 1994. Recruitment will continue through September 1995, with the last demonstration HHA implementing the per episode payment system in January 1996.

90-017 Policy Study of the Cost Effectiveness of Institutional Subacute Care Alternatives and Services: 1984–92

Project No.:	18-C-99491/8
Period:	May 1990–August 1995
Funding:	$ 1,427,400
Award:	Cooperative Agreement
Principal Investigator:	Andrew Kramer, M.D.
Awardee:	University of Colorado Health Sciences Center 1355 South Colorado Boulevard Denver, CO 80222
HCFA Project Officer:	Judith A. Sangl, Sc.D. Division of Health Information and Outcomes

Description: The University of Colorado will assess which subacute institutional settings and combinations of services are most cost-effective and provide more positive outcomes for various types of patients. Researchers will identify potential Health Care Financing Administration (HCFA) policy changes that might encourage use of the most appropriate settings and services. This project will use primary and secondary data from three previous HCFA-sponsored studies to compare quality, cost effectiveness, case mix, service mix, and utilization among institutional subacute care alternatives (e.g., skilled nursing facilities (SNFs) and rehabilitation hospitals) within and between two periods: 1984–87 and 1990–92; the longitudinal admission sample is for the period 1992–94. This methodology is designed to determine the most cost-effective combinations of services and provider settings for various types of patients requiring subacute care (i.e., stroke and hip fracture). Functional-related groups and alternative groupings will be tested to explain variation in resource consumption. Several prospective and per case payment methods for selected types of subacute care will be modeled.

Status: Preliminary longitudinal analyses indicate different results regarding hip fracture and stroke outcomes and cost-effectiveness between rehabilitation and skilled nursing facilities. With respect to hip fractures:

- Patients with an amputation should be placed in rehabilitation facilities.
- Comparable hip fracture patients have equivalent outcomes at lower costs in skilled nursing facilities.
- Comparable hip fracture patients have equivalent outcomes in high-Medicare- volume sub-acute SNFs and low-Medicare- volume SNFs, despite cost differences.

With respect to stroke patients:

- Patients with coma, grade 3 or 4 pressure sores, the inability to walk 20 feet before their stroke should be placed in SNFs.
- Comparable stroke patients have better outcomes in rehabilitation facilities than SNFs, but at higher cost.
- Comparable stroke patients have better outcomes in high-Medicare-volume sub-acute SNFs than low-Medicare-volume SNFs, but at higher cost.
- Functional outcomes at 6 months are better for some stroke patients admitted to rehabilitation facilities than high-Medicare- volume subacute SNFs, but at higher cost.

92-100 Potential of Coordinated Care Targeted to Medicare Beneficiaries with Medicaid Coverage (Formerly, Long-Term Care Studies (Section 207))

Project No.:	500-89-0047/33
Period:	April 1992–August 1992
Funding:	$ 18,500
Award:	Contract
Principal Investigator:	David Kennell
Awardee:	Lewin/VHI, Inc. (See page 148)
HCFA Project Officer:	Carolyn Rimes Division of Aging and Disability

Description: The purpose of this paper was to discuss the potential for coordinating health service delivery and financing among the population eligible for both Medicare and Medicaid financing (the "dual eligibles"). First, it discussed the interactions between Medicare and Medicaid eligibility and financing for services and then presented a description of the characteristics and health service use by the dual eligibles. Second, it explored the potential benefits of care coordination and management among this population and addressed lessons learned and relevant issues in developing coordinated care targeted to the dual eligibles.

Status: This paper found that although dual eligibles typically use high amounts of both Medicare and Medicaid services (where Medicaid primarily funds chronic care services among Medicare beneficiaries), there is very little coordination between the two programs. Dual eligibles tend to be poor females living in the community. Nearly one-third of the noninstitutionalized Medicare beneficiaries under 65 years of age also are receiving Medicaid. The final report has been received and is being reviewed.

94-085 **Predictors of Access and Effects of Medicare Post-Hospital Care for Beneficiaries 65 Years of Age or Over**

Project No.:	17-C-90395/3
Period:	September 1994–September 1996
Funding:	$ 502,614
Award:	Cooperative Agreement
Principal Investigator:	David L. Rabin, Ph.D.
Awardee:	Georgetown University Division of Community Health Studies and Family Medicine 3750 Reservoir Road, NW. Washington, DC 20007-2197
HCFA Project Officer:	Carolyn Rimes Division of Aging and Disability

Description: As a consequence of regulatory and legislative changes in the late 1980s, Medicare post-hospital care (PHC) has become the most rapidly growing Medicare expenditure. PHC consists of home health care, inpatient skilled nursing facility care, and rehabilitation hospital care. The growth in use, changes in eligibility requirements, and the increase in Medicare costs have raised questions about equal access and the effects of PHC use. The literature on PHC suggests two important trends. A few Medicare prospective payment inpatient hospital diagnosis-related groups (DRG) account for most PHC, but within these DRGs large variations exist in use. Personal health, economic, sociodemographic, and household factors, as well as area and health system characteristics, are predictive of the use of PHC despite equal access under the Medicare program. This study uses the Medicare Current Beneficiary Survey to investigate three major research objectives:

- Describe the personal, area, and health system characteristics of users and those of similar persons with unmet needs for PHC in order to assess differences by gender, race, and income class and the potential for substitution of care modes.
- Study the longitudinal effects of PHC on Medicare program costs an rehospitalization.
- Study the personal health effects associated with PHC.

Status: This project is in the development phase.

90-003 **Program of All-Inclusive Care for the Elderly: Beth Abraham Hospital** (Formerly, Frail Elderly Demonstration: The Program for All-Inclusive Care for the Elderly)

Project No.:	95-P-99361
Period:	October 1989–January 1995 (yearly continuation)
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Susan Aldrich
Awardee:	Beth Abraham Hospital 612 Allerton Avenue Bronx, NY 10467
HCFA Project Officer:	Stefan N. Miller Division of Aging and Disability
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: Mandated by Public Law 99-509, as amended by section 4118(g)(1)(2) of Public Law 100-203 and section 4744 of Public Law 101-508, the Health Care Financing Administration will conduct a demonstration that replicates, in not more than 15 sites, the model of care developed by On Lok Senior Health Services in San Francisco, California. The Program of All-Inclusive Care for the Elderly demonstration replicates a unique model of managed care service delivery for 300 very frail community-dwelling elderly persons, most of whom are dually eligible for Medicare and Medicaid coverage and all of whom are assessed as being eligible for nursing home placement, according to the standards established by participating States. The model of care includes as core services the provision of adult day health care and multidisciplinary case management through which access to and allocation of all health and long-term care services are arranged. Physician, therapeutic, ancillary, and social support services are provided on site at the adult day health center whenever possible. Hospital, nursing home, home health, and other specialized services are provided off site. Transportation is provided for all enrolled members who require it. This model is financed through prospective capitation of both Medicare and Medicaid payments to the provider. Demonstration sites are to assume financial risk progressively over 3 years, as stipulated in the Omnibus Budget Reconciliation Act of 1987.

Status: Plans to expand services to Westchester County and to another area of Manhattan have been delayed. The Westchester renovation is scheduled to begin by summer/fall 1995. Space availability caused the delay in locating a new Manhattan site; however, a potential site has now been identified, and negotiations have begun. The anticipated start date for services in this new site is early 1996.

92-005 **Program of All-Inclusive Care for the Elderly: Bienvivir Senior Health Services** (Formerly, Frail Elderly Demonstration: The Program for All-Inclusive Care for the Elderly)

Project No.:	95-P-99649
Period:	December 1991–May 1995 (yearly continuation)
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Rosemary Castillo
Awardee:	Bienvivir Senior Health Services 6000 Welch, Suite A-2 El Paso, TX 77905-1753
HCFA Project Officer:	Stefan N. Miller Division of Aging and Disability
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: Mandated by Public Law 99-509, as amended by section 4118(g)(1)(2) of Public Law 100-203 and section 4744 of Public Law 101-508, the Health Care Financing Administration will conduct a demonstration that replicates, in not more than 15 sites, the model of care developed by On Lok Senior Health Services in San Francisco, California. The Program of All-Inclusive Care for the Elderly demonstration replicates a unique model of managed care service delivery for 300 very frail community-dwelling elderly persons, most of whom are dually eligible for Medicare and Medicaid coverage and all of whom are assessed as being eligible for nursing home placement, according to the standards established by participating States. The model of care includes as core services the provision of adult day health care and multidisciplinary case management through which access to and allocation of all health and long-term care services are arranged. Physician, therapeutic, ancillary, and social support services are provided on site at the adult day health center whenever possible. Hospital, nursing home, home health, and other specialized services are provided off site. Transportation is provided for all enrolled members who require it. This model is financed through prospective capitation of both Medicare and Medicaid payments to the provider. Demonstration sites are to assume financial risk progressively over 3 years, as stipulated in the Omnibus Budget Reconciliation Act of 1987.

Status: This site has received a Housing and Urban Development 202 grant to build a residential structure and is in the process of implementing this opportunity.

95-092 **Program of All-Inclusive Care for the Elderly: California Department of Health Services** (Formerly, Frail Elderly Demonstration: The Program for All-Inclusive Care for the Elderly)

Project No.:	11-P-90485
Period:	April 1995–March 1998 (yearly continuation)
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Louise Nava
Awardee:	Department of Health Services 712/744 P Street P.O. Box 942732 Sacramento, California 95814
HCFA Project Officer:	Stefan N. Miller Division of Aging and Disability
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: Mandated by Public Law 99-509, as amended by section 4118(g)(1)(2) of Public Law 100-203 and section 4744 of Public Law 101-508, the Health Care Financing Administration will conduct a demonstration that replicates, in not more than 15 sites, the model of care developed by On Lok Senior Health Services in San Francisco, California. The Program of All-Inclusive Care for the Elderly demonstration replicates a unique model of managed care service delivery for 300 very frail community-dwelling elderly persons, most of whom are dually eligible for Medicare and Medicaid coverage and all of whom are assessed as being eligible for nursing home placement, according to the standards established by participating States. The model of care includes as core services the provision of adult day health care and multidisciplinary case management through which access to and allocation of all health and long-term care services are arranged. Physician, therapeutic, ancillary, and social support services are provided on site at the adult day health center whenever possible. Hospital, nursing home, home health, and other specialized services are provided off site. Transportation is provided for all enrolled members who require it. This model is financed through prospective capitation of both Medicare and Medicaid payments to the provider. Demonstration sites are to assume financial risk progressively over 3 years, as stipulated in the Omnibus Budget Reconciliation Act of 1987. The 10 sites and their State Medicaid agencies that have been granted waiver approval to provide services are East Boston Geriatric Services, Inc.; Providence Medical Center; Total Longterm

Care, Inc.; Rochester General Hospital; Sutter Health System; Beth Abraham Hospital; Richland Memorial Hospital; Bienvivir Senior Health Services; Community Care Organization; and Center for Elders' Independence.

Status: The State continues to be supportive of the site's program.

94-061 Program of All-Inclusive Care for the Elderly: California Department of Health Services

Project No.:	11-P-90485
Period:	May 1994–April 1997 (yearly continuation)
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Louise Nava
Awardee:	California Department of Health Services 714/744 P Street P.O. Box 942732 Sacramento, CA 94234-7320
HCFA Project Officer:	Stefan N. Miller Division of Aging and Disability
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: Mandated by Public Law 99-509, as amended by section 4118(g)(1)(2) of Public Law 100-203 and section 4744 of Public Law 101-508, the Health Care Financing Administration will conduct a demonstration that replicates, in not more than 15 sites, the model of care developed by On Lok Senior Health Services in San Francisco, California. The Program of All-Inclusive Care for the Elderly demonstration replicates a unique model of managed care service delivery for 300 very frail community-dwelling elderly persons, most of whom are dually eligible for Medicare and Medicaid coverage and all of whom are assessed as being eligible for nursing home placement, according to the standards established by participating States. The model of care includes as core services the provision of adult day health care and multidisciplinary case management through which access to and allocation of all health and long-term care services are arranged. Physician, therapeutic, ancillary, and social support services are provided on site at the adult day health center whenever possible. Hospital, nursing home, home health, and other specialized services are provided off site. Transportation is provided for all enrolled members who require it. This model is financed through prospective capitation of both Medicare and Medicaid payments to the provider. Demonstration sites are to assume financial risk progressively over 3 years, as stipulated in the Omnibus Budget Reconciliation Act of 1987. The 10 sites and their State Medicaid agencies that have been granted waiver approval to provide services are East Boston Geriatric Services, Inc.; Providence Medical Center; Total Longterm Care, Inc.; Rochester General Hospital; Sutter Health System; Beth Abraham Hospital; Richland Memorial Hospital; Bienvivir Senior Health Services; Community Care Organization; and Center for Elders' Independence.

Status: The State continues to provide support and oversight to this site.

95-093 Program of All-Inclusive Care for the Elderly: Center for Elders' Independence

(Formerly, Frail Elderly Demonstration: The Program for All-Inclusive Care for the Elderly)

Project No.:	95-P-90653
Period:	April 1995–March 1998 (yearly continuation)
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Peter Szutu
Awardee:	Center for Elders' Independence 1411 East 31st Street Ward B2 Oakland, California 94602
HCFA Project Officer:	Stefan N. Miller Division of Aging and Disability
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: Mandated by Public Law 99-509, as amended by section 4118(g)(1)(2) of Public Law 100-203 and section 4744 of Public Law 101-508, the Health Care Financing Administration will conduct a demonstration that replicates, in not more than 15 sites, the model of care developed by On Lok Senior Health Services in San Francisco, California. The Program of All-Inclusive Care for the Elderly demonstration replicates a unique model of managed care service delivery for 300 very frail community-dwelling elderly persons, most of whom are dually eligible for Medicare and Medicaid coverage and all of whom are assessed as being eligible for nursing home placement, according to the standards established by participating States. The model of care includes as core services the provision of adult day health care and multidisciplinary case management through which access to and allocation of all health and long-term care services are arranged. Physician, therapeutic, ancillary, and social support services are provided on site at the adult day health center whenever possible. Hospital, nursing home, home health, and other specialized services are provided off site.

Transportation is provided for all enrolled members who require it. This model is financed through prospective capitation of both Medicare and Medicaid payments to the provider. Demonstration sites are to assume financial risk progressively over 3 years, as stipulated in the Omnibus Budget Reconciliation Act of 1987.

Status: The site anticipates that it will occupy it second adult day health center (ADHC) by the start of 1996. This ADHC is part of a residential complex that will house a significant number of the Center for Elders' Independence participants.

91-066 **Program of All-Inclusive Care for the Elderly: Colorado Department of Social Services** (Formerly, Frail Elderly Demonstration: The Program for All-Inclusive Care for the Elderly)

Project No.:	11-P-99646
Period:	August 1991–September 1994 (yearly continuation)
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Carol Workman-Allen
Awardee:	Colorado Department of Social Services 1575 Sherman Street Denver, CO 80203-1714
HCFA Project Officer:	Stefan N. Miller Division of Aging and Disability
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: Mandated by Public Law 99-509, as amended by section 4118(g)(1)(2) of Public Law 100-203 and section 4744 of Public Law 101-508, the Health Care Financing Administration will conduct a demonstration that replicates, in not more than 15 sites, the model of care developed by On Lok Senior Health Services in San Francisco, California. The Program of All-Inclusive Care for the Elderly demonstration replicates a unique model of managed care service delivery for 300 very frail community-dwelling elderly persons, most of whom are dually eligible for Medicare and Medicaid coverage and all of whom are assessed as being eligible for nursing home placement, according to the standards established by participating States. The model of care includes as core services the provision of adult day health care and multidisciplinary case management through which access to and allocation of all health and long-term care services are arranged. Physician, therapeutic, ancillary, and social support services are provided on site at the adult day health center whenever possible. Hospital, nursing home, home health, and other specialized services are provided off site. Transportation is provided for all enrolled members who require it. This model is financed through prospective capitation of both Medicare and Medicaid payments to the provider. Demonstration sites are to assume financial risk progressively over 3 years, as stipulated in the Omnibus Budget Reconciliation Act of 1987. The 10 sites and their State Medicaid agencies that have been granted waiver approval to provide services are East Boston Geriatric Services, Inc.; Providence Medical Center; Total Longterm Care, Inc.; Rochester General Hospital; Sutter Health System; Beth Abraham Hospital; Richland Memorial Hospital; Bienvivir Senior Health Services; Community Care Organization; and Center for Elders' Independence.

Status: The Department of Health Care Policy and Financing and the University of Colorado evaluated the PACE project and submitted the report to the State legislature in November 1994. The report recommended that the State continue to support the program.

90-045 **Program of All-Inclusive Care for the Elderly: Community Care Organization** (Formerly, Frail Elderly Demonstration: The Program for All-Inclusive Care for the Elderly)

Project No.:	95-P-99628
Period:	August 1990–October 1994 (yearly continuation)
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Kirby G. Shoaf
Awardee:	Community Care Organization 5228 West Fond du Lac Avenue Milwaukee, WI 53216
HCFA Project Officer:	Stefan N. Miller Division of Aging and Disability
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: Mandated by Public Law 99-509, as amended by section 4118(g)(1)(2) of Public Law 100-203 and section 4744 of Public Law 101-508, the Health Care Financing Administration will conduct a demonstration that replicates, in not more than 15 sites, the model of care developed by On Lok Senior Health Services in San Francisco, California. The Program of All-Inclusive Care for the Elderly demonstration replicates a unique model of managed care service delivery for 300 very frail community-dwelling elderly persons, most of whom are

dually eligible for Medicare and Medicaid coverage and all of whom are assessed as being eligible for nursing home placement, according to the standards established by participating States. The model of care includes as core services the provision of adult day health care and multidisciplinary case management through which access to and allocation of all health and long-term care services are arranged. Physician, therapeutic, ancillary, and social support services are provided on site at the adult day health center whenever possible. Hospital, nursing home, home health, and other specialized services are provided off site. Transportation is provided for all enrolled members who require it. This model is financed through prospective capitation of both Medicare and Medicaid payments to the provider. Demonstration sites are to assume financial risk progressively over 3 years, as stipulated in the Omnibus Budget Reconciliation Act of 1987.

Status: During the past year, Community Care Organization began offering services at a fourth adult day health center site.

92-101 Program for All-Inclusive Care for the Elderly Data Management

Project No.:	500-92-0007
Period:	March 1992–August 1995
Funding:	$ 613,014
Award:	Contract
Principal Investigator:	Marleen L. Clark, Ph.D.
Awardee:	On Lok, Inc. 1333 Bush Street San Francisco, CA 94109
HCFA Project Officer:	Kay Lewandowski Division of Aging and Disability

Description: The purpose of this project is to provide continuing data management throughout the Program for All-Inclusive Care for the Elderly (PACE) demonstration period to ensure that a valid, reliable data set is maintained for monitoring project operations and for use by the Health Care Financing Administration's independent evaluator. The PACE demonstration replicates a unique model of managed care service delivery for very frail community-dwelling elderly persons, most of whom are dually eligible for Medicare and Medicaid coverage and all of whom are assessed as being eligible for nursing home placement according to the standards established by the participating States. DataPACE maintains a data set on PACE enrollees, including demographic and enrollment information, health and functional status, and service use. For the PACE demonstration project, On Lok has established a minimum data set and has implemented data collection procedures at the PACE sites for this data set. This data set includes the variables and program information originally designed to be used by evaluators.

Status: The final report for this project has been received and is currently under review.

90-010 Program of All-Inclusive Care for the Elderly: East Boston Geriatric Services, Inc. (Formerly, Frail Elderly Demonstration: The Program for All-Inclusive Care for the Elderly)

Project No.:	95-P-99357
Period:	October 1989–May 1994 (yearly continuation)
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Jean Masland
Awardee:	East Boston Geriatric Services, Inc. 10 Gove Street Boston, MA 02128
HCFA Project Officer:	Stefan N. Miller Division of Aging and Disability
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: Mandated by Public Law 99-509, as amended by section 4118(g)(1)(2) of Public Law 100-203 and section 4744 of Public Law 101-508, the Health Care Financing Administration will conduct a demonstration that replicates, in not more than 15 sites, the model of care developed by On Lok Senior Health Services in San Francisco, California. The Program of All-Inclusive Care for the Elderly demonstration replicates a unique model of managed care service delivery for 300 very frail community-dwelling elderly persons, most of whom are dually eligible for Medicare and Medicaid coverage and all of whom are assessed as being eligible for nursing home placement, according to the standards established by participating States. The model of care includes as core services the provision of adult day health care and multidisciplinary case management through which access to and allocation of all health and long-term care services are arranged. Physician, therapeutic, ancillary, and social support services are provided on site at the adult day health center whenever possible. Hospital, nursing home, home health, and other specialized services are provided off site. Transportation is provided for all enrolled members who require it. This model is financed through prospective capitation of both Medicare and Medicaid payments to the provider. Demonstration sites are to assume financial risk progressively over 3 years, as stipulated in the Omnibus Budget Reconciliation Act of 1987.

Status: East Boston is expecting the conversion of the Winthrop Health Center into a transitional housing unit by the end of 1995. This project will combine a 13-bed housing site with a 4-bed transitional service.

93-098 (Withdrew from the program) **Program for All-Inclusive Care for the Elderly: Illinois Department of Public Aid** (Formerly, Frail Elderly Demonstration: The Program for All-Inclusive Care for the Elderly)

Project No.:	11-P-90236
Period:	April 1993–March 1996 (yearly continuation)
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Melinda Hazelwood
Awardee:	Illinois Department of Public Aid 201 South Grand Avenue East Springfield, IL 62763-0001
HCFA Project Officer:	Stefan N. Miller Division of Aging and Disability
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: Mandated by Public Law 99-509, as amended by section 4118(g)(1)(2) of Public Law 100-203 and section 4744 of Public Law 101-508, the Health Care Financing Administration will conduct a demonstration that replicates, in not more than 15 sites, the model of care developed by On Lok Senior Health Services in San Francisco, California. The Program for All-Inclusive Care for the Elderly (PACE) demonstration replicates a unique model of managed care service delivery for 300 very frail community-dwelling elderly persons, most of whom are dually eligible for Medicare and Medicaid coverage and all of whom are assessed as being eligible for nursing home placement, according to the standards established by participating States. The model of care includes as core services the provision of adult day health care and multidisciplinary case management through which access to and allocation of all health and long-term care services are arranged. Physician, therapeutic, ancillary, and social support services are provided on site at the adult day health center whenever possible. Hospital, nursing home, home health, and other specialized services are provided off site. Transportation is provided for all enrolled members who require it. This model is financed through prospective capitation of both Medicare and Medicaid payments to the provider. Demonstration sites are to assume financial risk progressively over 3 years, as stipulated in the Omnibus Budget Reconciliation Act of 1987. The nine sites and their State Medicaid agencies that have been granted waiver approval to provide services are East Boston Geriatric Services, Inc.; Providence Medical Center; Total Longterm Care, Inc.; Rochester General Hospital; Sutter Health System; Beth Abraham Hospital; Richland Memorial Hospital; Bienvivir Senior Health Services; and Community Care Organization.

Status: The site voluntarily withdrew from the PACE demonstration effective April 30, 1994. As a result the State waiver ended.

90-009 **Program of All-Inclusive Care for the Elderly: Massachusetts State Department of Public Welfare** (Formerly, Frail Elderly Demonstration: The Program for All-Inclusive Care for the Elderly)

Project No.:	11-P-99356
Period:	October 1989–May 1994 (yearly continuation)
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Diane Flanders
Awardee:	Massachusetts Department of Public Welfare 180 Tremont Street Boston, MA 02111
HCFA Project Officer:	Stefan N. Miller Division of Aging and Disability
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: Mandated by Public Law 99-509, as amended by section 4118(g)(1)(2) of Public Law 100-203 and section 4744 of Public Law 101-508, the Health Care Financing Administration will conduct a demonstration that replicates, in not more than 15 sites, the model of care developed by On Lok Senior Health Services in San Francisco, California. The Program of All-Inclusive Care for the Elderly (PACE) demonstration replicates a unique model of managed care service delivery for 300 very frail community-dwelling elderly persons, most of whom are dually eligible for Medicare and Medicaid coverage and all of whom are assessed as being eligible for nursing home placement, according to the standards established by participating States. The model of care includes as core services the provision of adult day health care and multidisciplinary case management through which access to

and allocation of all health and long-term care services are arranged. Physician, therapeutic, ancillary, and social support services are provided on site at the adult day health center whenever possible. Hospital, nursing home, home health, and other specialized services are provided off site. Transportation is provided for all enrolled members who require it. This model is financed through prospective capitation of both Medicare and Medicaid payments to the provider. Demonstration sites are to assume financial risk progressively over 3 years, as stipulated in the Omnibus Budget Reconciliation Act of 1987. The 10 sites and their State Medicaid agencies that have been granted waiver approval to provide services are East Boston Geriatric Services, Inc.; Providence Medical Center; Total Longterm Care, Inc.; Rochester General Hospital; Sutter Health System; Beth Abraham Hospital; Richland Memorial Hospital; Bienvivir Senior Health Services; Community Care Organization; and Center for Elders' Independence.

Status: The State is hoping to develop six additional PACE sites.

90-004 **Program of All-Inclusive Care for the Elderly: New York State Department of Social Services, October 1989–January 1995**
(Formerly, Frail Elderly Demonstration: The Program for All-Inclusive Care for the Elderly)

Project No.:	11-P-99360
Period:	October 1989–January 1995 (yearly continuation)
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Christopher Rush
Awardee:	New York State Department of Social Services 40 North Pearl Street Albany, NY 12243-0001
HCFA Project Officer:	Stefan N. Miller Division of Aging and Disability
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: Mandated by Public Law 99-509, as amended by section 4118(g)(1)(2) of Public Law 100-203 and section 4744 of Public Law 101-508, the Health Care Financing Administration will conduct a demonstration that replicates, in not more than 15 sites, the model of care developed by On Lok Senior Health Services in San Francisco, California. The Program of All-Inclusive Care for the Elderly demonstration replicates a unique model of managed care service delivery for 300 very frail community-dwelling elderly persons, most of whom are dually eligible for Medicare and Medicaid coverage and all of whom are assessed as being eligible for nursing home placement, according to the standards established by participating States. The model of care includes as core services the provision of adult day health care and multidisciplinary case management through which access to and allocation of all health and long-term care services are arranged. Physician, therapeutic, ancillary, and social support services are provided on site at the adult day health center whenever possible. Hospital, nursing home, home health, and other specialized services are provided off site. Transportation is provided for all enrolled members who require it. This model is financed through prospective capitation of both Medicare and Medicaid payments to the provider. Demonstration sites are to assume financial risk progressively over 3 years, as stipulated in the Omnibus Budget Reconciliation Act of 1987. The 10 sites and their State Medicaid agencies that have been granted waiver approval to provide services are East Boston Geriatric Services, Inc.; Providence Medical Center; Total Longterm Care, Inc.; Rochester General Hospital; Sutter Health System; Beth Abraham Hospital; Richland Memorial Hospital; Bienvivir Senior Health Services; Community Care Organization; and Center for Elders' Independence.

Status: During the year, the State performed a survey of Beth Abraham's program and found it to be in compliance with applicable State and Federal laws and regulations.

92-033 **Program of All-Inclusive Care for the Elderly: New York State Department of Social Services, March 1992–March 1995**
(Formerly, Frail Elderly Demonstration: The Program for All-Inclusive Care for the Elderly)

Project No.:	11-P-99357
Period:	March 1992–March 1995 (yearly continuation)
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Christopher Rush
Awardee:	New York State Department of Social Services 40 North Pearl Street Albany, NY 12243-0001
HCFA Project	Stefan N. Miller

Officer: Division of Aging and Disability

Mandates: Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509)
Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203)
Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: Mandated by Public Law 99-509, as amended by section 4118(g)(1)(2) of Public Law 100-203 and section 4744 of Public Law 101-508, the Health Care Financing Administration will conduct a demonstration that replicates, in not more than 15 sites, the model of care developed by On Lok Senior Health Services in San Francisco, California. The Program of All-Inclusive Care for the Elderly demonstration replicates a unique model of managed care service delivery for 300 very frail community-dwelling elderly persons, most of whom are dually eligible for Medicare and Medicaid coverage and all of whom are assessed as being eligible for nursing home placement, according to the standards established by participating States. The model of care includes as core services the provision of adult day health care and multidisciplinary case management through which access to and allocation of all health and long-term care services are arranged. Physician, therapeutic, ancillary, and social support services are provided on site at the adult day health center whenever possible. Hospital, nursing home, home health, and other specialized services are provided off site. Transportation is provided for all enrolled members who require it. This model is financed through prospective capitation of both Medicare and Medicaid payments to the provider. Demonstration sites are to assume financial risk progressively over 3 years, as stipulated in the Omnibus Budget Reconciliation Act of 1987. The 10 sites and their State Medicaid agencies that have been granted waiver approval to provide services are East Boston Geriatric Services, Inc.; Providence Medical Center; Total Longterm Care, Inc.; Rochester General Hospital; Sutter Health System; Beth Abraham Hospital; Richland Memorial Hospital; Bienvivir Senior Health Services; Community Care Organization; and the Center for Elders' Independence.

Status: The State continues to find that the site is in compliance with applicable State and Federal requirements.

90-007 **Program of All-Inclusive Care for the Elderly: Oregon State Department of Human Services** (Formerly, Frail Elderly Demonstration: The Program for All-Inclusive Care for the Elderly)

Project No.: 11-P-99358
Period: October 1989–May 1994 (yearly continuation)
Funding: Waiver only
Award: Grant
Principal Investigator: Rita Litwiller
Awardee: Oregon State Department of Human Services
313 Public Service Building
Salem, OR 97310
HCFA Project Officer: Stefan N. Miller
Division of Aging and Disability
Mandates: Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509)
Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203)
Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: Mandated by Public Law 99-509, as amended by section 4118(g)(1)(2) of Public Law 100-203 and section 4744 of Public Law 101-508, the Health Care Financing Administration will conduct a demonstration that replicates, in not more than 15 sites, the model of care developed by On Lok Senior Health Services in San Francisco, California. The Program of All-Inclusive Care for the Elderly demonstration replicates a unique model of managed care service delivery for 300 very frail community-dwelling elderly persons, most of whom are dually eligible for Medicare and Medicaid coverage and all of whom are assessed as being eligible for nursing home placement, according to the standards established by participating States. The model of care includes as core services the provision of adult day health care and multidisciplinary case management through which access to and allocation of all health and long-term care services are arranged. Physician, therapeutic, ancillary, and social support services are provided on site at the adult day health center whenever possible. Hospital, nursing home, home health, and other specialized services are provided off site. Transportation is provided for all enrolled members who require it. This model is financed through prospective capitation of both Medicare and Medicaid payments to the provider. Demonstration sites are to assume financial risk progressively over 3 years, as stipulated in the Omnibus Budget Reconciliation Act of 1987. The 10 sites and their State Medicaid agencies that have been granted waiver approval to provide services are East Boston Geriatric Services, Inc.; Providence Medical Center; Total Longterm Care, Inc.; Rochester General Hospital; Sutter Health System; Beth Abraham Hospital; Richland Memorial Hospital; Bienvivir Senior Health Services; Community Care Organization; and Center for Elders' Independence.

Status: The State is continuing to work with the site on a capitation methodology.

90-008 **Program of All-Inclusive Care for the Elderly: Providence Medical Center** (Formerly, Frail Elderly Demonstration: The Program for All-Inclusive Care for the Elderly)

Project No.:	95-P-99359
Period:	October 1989–May 1994 (yearly continuation)
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Don Keister
Awardee:	Providence Medical Center 4805 Northeast Glisan Street Portland, OR 97213
HCFA Project Officer:	Stefan N. Miller Division of Aging and Disability
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: Mandated by Public Law 99-509, as amended by section 4118(g)(1)(2) of Public Law 100-203 and section 4744 of Public Law 101-508, the Health Care Financing Administration will conduct a demonstration that replicates, in not more than 15 sites, the model of care developed by On Lok Senior Health Services in San Francisco, California. The Program of All-Inclusive Care for the Elderly demonstration replicates a unique model of managed care service delivery for 300 very frail community-dwelling elderly persons, most of whom are dually eligible for Medicare and Medicaid coverage and all of whom are assessed as being eligible for nursing home placement, according to the standards established by participating States. The model of care includes as core services the provision of adult day health care and multidisciplinary case management through which access to and allocation of all health and long-term care services are arranged. Physician, therapeutic, ancillary, and social support services are provided on site at the adult day health center whenever possible. Hospital, nursing home, home health, and other specialized services are provided off site. Transportation is provided for all enrolled members who require it. This model is financed through prospective capitation of both Medicare and Medicaid payments to the provider. Demonstration sites are to assume financial risk progressively over 3 years, as stipulated in the Omnibus Budget Reconciliation Act of 1987.

Status: A new 42-unit housing structure, Cully Place, is scheduled for completion in 1996. Cully Place will also contain the third adult day health center and will be able to provide services to 110 enrollees. PEP is also considering expanding its services beyond Multnomah County.

90-043 **Program of All-Inclusive Care for the Elderly: Richland Memorial Hospital** (Formerly, Frail Elderly Demonstration: The Program for All-Inclusive Care for the Elderly)

Project No.:	95-P-99630
Period:	August 1990–September 1994 (yearly continuation)
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Judy Baskins
Awardee:	Richland Memorial Hospital Fifteen Richland Medical Park Columbia, SC 29203
HCFA Project Officer:	Stefan N. Miller Division of Aging and Disability
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: Mandated by Public Law 99-509, as amended by section 4118(g)(1)(2) of Public Law 100-203 and section 4744 of Public Law 101-508, the Health Care Financing Administration will conduct a demonstration that replicates, in not more than 15 sites, the model of care developed by On Lok Senior Health Services in San Francisco, California. The Program of All-Inclusive Care for the Elderly demonstration replicates a unique model of managed care service delivery for 300 very frail community-dwelling elderly persons, most of whom are dually eligible for Medicare and Medicaid coverage and all of whom are assessed as being eligible for nursing home placement, according to the standards established by participating States. The model of care includes as core services the provision of adult day health care and multidisciplinary case management through which access to and allocation of all health and long-term care services are arranged. Physician, therapeutic, ancillary, and social support services are provided on site at the adult day health center whenever possible. Hospital, nursing home, home health, and other specialized services are provided off site. Transportation is provided to all enrolled members who require it. This model is financed through prospective

capitation of both Medicare and Medicaid payment to the provider. Demonstration sites are to assume financial risk progressively over 3 years, as stipulated in the Omnibus Budget Reconciliation Act of 1987.

Status: Renovations undertaken at the Shandon Day Health Center are scheduled to be completed by early 1996. This center is continuing to operate during renovation and is one of three centers now in operation. A dementia-specific program is now being implemented at the Eau Claire Center.

92-032 **Program of All-Inclusive Care for the Elderly: Rochester General Hospital** (Formerly, Frail Elderly Demonstration: The Program for All-Inclusive Care for the Elderly)

Project No.:	95-P-99660
Period:	March 1992–March 1995 (yearly continuation)
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Kathryn McGuire
Awardee:	Rochester General Hospital 311 Alexander Street Rochester, NY 14604
HCFA Project Officer:	Stefan N. Miller Division of Aging and Disability
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: Mandated by Public Law 99-509, as amended by section 4118(g)(1)(2) of Public Law 100-203 and section 4744 of Public Law 101-508, the Health Care Financing Administration will conduct a demonstration that replicates, in not more than 15 sites, the model of care developed by On Lok Senior Health Services in San Francisco, California. The Program of All-Inclusive Care for the Elderly demonstration replicates a unique model of managed care service delivery for 300 very frail community-dwelling elderly persons, most of whom are dually eligible for Medicare and Medicaid coverage and all of whom are assessed as being eligible for nursing home placement, according to the standards established by participating States. The model of care includes as core services the provision of adult day health care and multidisciplinary case management through which access to and allocation of all health and long-term care services are arranged. Physician, therapeutic, ancillary, and social support services are provided on site at the adult day health center whenever possible. Hospital, nursing home, home health, and other specialized services are provided off site. Transportation is provided for all enrolled members who require it. This model is financed through prospective capitation of both Medicare and Medicaid payments to the provider. Demonstration sites are to assume financial risk progressively over 3 years, as stipulated in the Omnibus Budget Reconciliation Act of 1987.

Status: Completion of the site's third residential facility occurred during the year.

90-044 **Program of All-Inclusive Care for the Elderly: South Carolina State Health and Human Services Finance Commission** (Formerly, Frail Elderly Demonstration: The Program for All-Inclusive Care for the Elderly)

Project No.:	11-P-99629
Period:	August 1990–September 1994 (yearly continuation)
Funding	Waiver only
Award:	Grant
Principal Investigator:	Nicki Harvey
Awardee:	South Carolina State Health and Human Services Finance Commission P.O. Box 8206 Columbia, SC 29202-8206
HCFA Project Officer:	Stefan N. Miller Division of Aging and Disability
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: Mandated by Public Law 99-509, as amended by section 4118(g)(1)(2) of Public Law 100-203 and section 4744 of Public Law 101-508, the Health Care Financing Administration will conduct a demonstration that replicates, in not more than 15 sites, the model of care developed by On Lok Senior Health Services in San Francisco, California. The Program of All-Inclusive Care for the Elderly demonstration replicates a unique model of managed care service delivery for 300 very frail community-dwelling elderly persons, most of whom are dually eligible for Medicare and Medicaid coverage and all of whom are assessed as being eligible for nursing home placement, according to the standards established by participating States. The model of care includes as core services the provision of adult day health care and multidisciplinary case management through which access to and allocation of all health and long-term care services are arranged. Physician, therapeutic, ancillary, and social support services are provided on site at the adult day health center whenever possible. Hospital, nursing home, home

health, and other specialized services are provided off site. Transportation is provided for all enrolled members who require it. This model is financed through prospective capitation of both Medicare and Medicaid payments to the provider. Demonstration sites are to assume financial risk progressively over 3 years, as stipulated in the Omnibus Budget Reconciliation Act of 1987. The 10 sites and their State Medicaid agencies that have been granted waiver approval to provide services are East Boston Geriatric Services, Inc.; Providence Medical Center; Total Longterm Care, Inc.; Rochester General Hospital; Sutter Health System; Beth Abraham Hospital; Richland Memorial Hospital; Bienvivir Senior Health Services; Community Care Organization; and Center for Elders' Independence.

Status: The State continues to be supportive of Palmetto Senior Care's program, and is now in the process of developing a client satisfaction survey.

94-040 Program for All-Inclusive Care for the Elderly: Sutter Health System

Project No.:	95-P-90484
Period:	May 1994–April 1997 (yearly continuation)
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Charla Wistos
Awardee:	Sutter Health System 2800 L Street Sacramento, CA 95816
HCFA Project Officer:	Stefan N. Miller Division of Aging and Disability
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: Mandated by Public Law 99-509, as amended by section 4118(g)(1)(2) of Public Law 100-203 and section 4744 of Public Law 101-508, the Health Care Financing Administration will conduct a demonstration that replicates, in not more than 15 sites, the model of care developed by On Lok Senior Health Services in San Francisco, California. The Program for All-Inclusive Care for the Elderly demonstration replicates a unique model of managed-care service delivery for 300 very frail community-dwelling elderly persons, most of whom are dually eligible for Medicare and Medicaid coverage and all of whom are assessed as being eligible for nursing home placement, according to the standards established by participating States. The model of care includes as core services the provision of adult day health care and multidisciplinary case management through which access to and allocation of all health and long-term care services are arranged. Physician, therapeutic, ancillary, and social support services are provided on site at the adult day health center whenever possible. Hospital, nursing home, home health, and other specialized services are provided off site. Transportation is provided for all enrolled members who require it. This model is financed through prospective capitation of both Medicare and Medicaid payments to the provider. Demonstration sites are to assume financial risk progressively over 3 years, as stipulated in the Omnibus Budget Reconciliation Act of 1987.

Status: Sutter Senior Care opened a new adult day health center site in March 1994.

92-006 Program of All-Inclusive Care for the Elderly: Texas Department of Human Services (Formerly, Frail Elderly Demonstration: The Program for All-Inclusive Care for the Elderly)

Project No.:	11-P-99648
Period:	December 1991–November 1995 (yearly continuation)
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Gerardo Cantu
Awardee:	Texas Department of Human Services P.O. Box 149030 (MC-E-601) Austin, TX 78714-9030
HCFA Project Officer:	Stefan N. Miller Division of Aging and Disability
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: Mandated by Public Law 99-509, as amended by section 4118(g)(1)(2) of Public Law 100-203 and section 4744 of Public Law 101-508, the Health Care Financing Administration will conduct a demonstration that replicates, in not more than 15 sites, the model of care developed by On Lok Senior Health Services in San Francisco, California. The Program of All-Inclusive Care for the Elderly demonstration replicates a unique model of managed care service delivery for 300 very frail community-dwelling elderly persons, most of whom are dually eligible for Medicare and Medicaid coverage and all of whom are assessed as being eligible for nursing home placement, according to the standards established by participating States. The model of care includes as core services the provision of adult day health care and multidisciplinary case management through which access to

and allocation of all health and long-term care services are arranged. Physician, therapeutic, ancillary, and social support services are provided on site at the adult day health center whenever possible. Hospital, nursing home, home health, and other specialized services are provided off site. Transportation is provided for all enrolled members who require it. This model is financed through prospective capitation of both Medicare and Medicaid payments to the provider. Demonstration sites are to assume financial risk progressively over 3 years, as stipulated in the Omnibus Budget Reconciliation Act of 1987. The 10 sites and their State Medicaid agencies that have been granted waiver approval to provide services are East Boston Geriatric Services, Inc.; Providence Medical Center; Total Longterm Care, Inc.; Rochester General Hospital; Sutter Health System; Beth Abraham Hospital; Richland Memorial Hospital; Bienvivir Senior Health Services; Community Care Organization; and the Center for Elders' Independence.

Status: The State continues to work very closely with Bienvivir Senior Health Services site. The State will continue to carry out periodic monitoring reviews and to offer administrative and professional assistance.

91-065 **Program of All-Inclusive Care for the Elderly: Total Longterm Care, Inc.** (Formerly, Frail Elderly Demonstration: The Program for All-Inclusive Care for the Elderly)

Project No.:	95-P-99647
Period:	August 1991–September 1994 (yearly continuation)
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Linda Barley
Awardee:	Total Longterm Care, Inc. 3202 West Colfax Denver, CO 80204
HCFA Project Officer:	Stefan N. Miller Division of Aging and Disability
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: Mandated by Public Law 99-509, as amended by section 4118(g)(1)(2) of Public Law 100-203 and section 4744 of Public Law 101-508, the Health Care Financing Administration will conduct a demonstration that replicates, in not more than 15 sites, the model of care developed by On Lok Senior Health Services in San Francisco, California. The Program of All-Inclusive Care for the Elderly demonstration replicates a unique model of managed care service delivery for 300 very frail community-dwelling elderly persons, most of whom are dually eligible for Medicare and Medicaid coverage and all of whom are assessed as being eligible for nursing home placement, according to the standards established by participating States. The model of care includes as core services the provision of adult day health care and multidisciplinary case management through which access to and allocation of all health and long-term care services are arranged. Physician, therapeutic, ancillary, and social support services are provided on site at the adult day health center whenever possible. Hospital, nursing home, home health, and other specialized services are provided off site. Transportation is provided for all enrolled members who require it. This model is financed through prospective capitation of both Medicare and Medicaid payments to the provider. Demonstration sites are to assume financial risk progressively over 3 years, as stipulated in the Omnibus Budget Reconciliation Act of 1987.

Status: Total Longterm Care began its fourth year of operation and its first under full risk.

93-036 (Withdrew from the program) **Program for All-Inclusive Care for the Elderly: Umoja Care, Inc.** (Formerly, Frail Elderly Demonstration: The Program for All-Inclusive Care for the Elderly)

Project No.:	95-P-90237
Period:	April 1993–March 1996 (yearly continuation)
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Mary Nelson
Awardee:	Umoja Care, Inc. 4501 West Augusta Boulevard Chicago, IL 60651
HCFA Project Officer:	Stefan N. Miller Division of Aging and Disability
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: Mandated by Public Law 99-509, as amended by section 4118(g)(1)(2) of Public Law 100-203 and section 4744 of Public Law 101-508, the Health Care Financing Administration will conduct a demonstration that replicates, in not more than 15 sites, the model of care developed by On Lok Senior Health Services in San Francisco, California. The Program for All-Inclusive Care for the Elderly demonstration replicates a unique model of managed-care service delivery for 300 very frail community-dwelling elderly persons, most of whom are dually eligible

for Medicare and Medicaid coverage and all of whom are assessed as being eligible for nursing home placement, according to the standards established by participating States. The model of care includes as core services the provision of adult day health care and multidisciplinary case management through which access to and allocation of all health and long-term care services are arranged. Physician, therapeutic, ancillary, and social support services are provided on site at the adult day health center whenever possible. Hospital, nursing home, home health, and other specialized services are provided off site. Transportation is provided for all enrolled members who require it. This model is financed through prospective capitation of both Medicare and Medicaid payments to the provider. Demonstration sites are to assume financial risk progressively over 3 years, as stipulated in the Omnibus Budget Reconciliation Act of 1987.

Status: This site voluntarily withdrew from the PACE demonstration, effective April 30, 1994.

90-046 **Program of All-Inclusive Care for the Elderly: Wisconsin State Department of Health and Social Services** (Formerly, Frail Elderly Demonstration: The Program for All-Inclusive Care for the Elderly)

Project No.:	11-P-99627
Period:	August 1990–October 1994 (yearly continuation)
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Ruth Belshaw
Awardee:	Wisconsin State Department of Health and Social Services P.O. Box 7850 Madison, WI 53707-7850
HCFA Project Officer:	Stefan N. Miller Division of Aging and Disability
Mandates:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: Mandated by Public Law 99-509, as amended by section 4118(g)(1)(2) of Public Law 100-203 and section 4744 of Public Law 101-508, the Health Care Financing Administration will conduct a demonstration that replicates, in not more than 15 sites, the model of care developed by On Lok Senior Health Services in San Francisco, California. The Program of All-Inclusive Care for the Elderly demonstration replicates a unique model of managed care service delivery for 300 very frail community-dwelling elderly persons, most of whom are dually eligible for Medicare and Medicaid coverage and all of whom are assessed as being eligible for nursing home placement, according to the standards established by participating States. The model of care includes as core services the provision of adult day health care and multidisciplinary case management through which access to and allocation of all health and long-term care services are arranged. Physician, therapeutic, ancillary, and social support services are provided on site at the adult day health center whenever possible. Hospital, nursing home, home health, and other specialized services are provided off site. Transportation is provided for all enrolled members who require it. This model is financed through prospective capitation of both Medicare and Medicaid payments to the provider. Demonstration sites are to assume financial risk progressively over 3 years, as stipulated in the Omnibus Budget Reconciliation Act of 1987. The 10 sites and their State Medicaid agencies that have been granted waiver approval to provide services are East Boston Geriatric Services, Inc.; Providence Medical Center; Total Longterm Care, Inc.; Rochester General Hospital; Sutter Health System; Beth Abraham Hospital; Richland Memorial Hospital; Bienvivir Senior Health Services; Community Care Organization; and Center for Elders' Independence.
Status: The State's continuing support of the PACE program is evidenced by its contracting with a program in Madison that is intent on furnishing PACE services to its population. In time, it is hoped that this pre-PACE program will eventually attain status as a PACE demonstration site.

94-096 **Project Demonstrating and Evaluating Alternative Methods to Assure and Enhance the Quality of Long-Term Care Services for Persons with Developmental Disabilities through Performance-Based Contracts with Service Providers**

Project No.:	11-C-90443/5
Period:	September 1994–September 1997
Funding:	$ 350,000
Award:	Cooperative Agreement
Principal Investigator:	Elaine J. Timmer
Awardee:	Minnesota Department of Human Services Health Care Administration 44 Lafayette Road St. Paul, MN 55155-3853
HCFA Project Officer:	Samuel L. Brown Division of Aging and Disability

Description: The purpose of this project is to determine whether and how well the implementation of new approaches to quality assurance, with outcome-based definitions and measures of quality, will replace the input

and process measures of quality and, in the process, contribute to improving the quality of life of persons with developmental disabilities. The Minnesota Department of Human Services will seek Federal authority to waive necessary provisions of the intermediate care facilities for the mentally retarded (ICF-MR) regulations to permit alternative quality assurance mechanisms in selected demonstration, residential, and support service programs. The department will enter into performance-based contracts with counties and participating ICF-MR providers. These contracts will specify the amount and conditions of reimbursement, requirements for monitoring and evaluation, and expected client-based outcomes. These client-based outcomes will be determined by the client and by the legal representative, if any, and with the assistance of the county case manager and provider. Some desirable outcomes include enhancement of consumer choice and autonomy, employment, and integration into the community. Criteria for measuring participating agency achievement will be drawn from, but not limited to, the outcome standards developed by the National Accreditation Council on Services for Persons with Developmental Disabilities; the "values experiences" of Frameworks for Accomplishment; and the goals established in Personal Futures Plans, Essential Lifestyle, and Person-Centered planning. According to the proposed quality assurance framework, monitoring of individual outcomes will be done jointly among family members, case managers, and other members of the local review team on a quarterly basis.

Status: The award was made to Minnesota Department of Human Services on September 30, 1994. The first year of the cooperative agreement was used to further develop the demonstration.

Significant progress has been made toward meeting the program objectives. Several approaches have been taken to develop alternative means of ensuring that quality services are provided. Providers were granted variances to existing State licensing rules governing ICF–MRs, waivered services, semi-independent living services and day training and habilitation services; waiver to parts of the rule licensing supervised living facilities; and changes to the statute governing case management through an established reform process.

A number of workshops were held with the goal of developing alternative means for measuring achievement of outcomes. In January 1995, Dr. Michael Patton conducted a workshop on the identification of client outcomes. Dr. Patton's presentation provided a process for outcome evaluation that is based on identifying client target groups, client goals, outcome indicators, and methods of data collection and establishing performance targets. In August 1995, the Accreditation Council on Services for Persons with Disabilities conducted a workshop on outcome-based approaches to service assessment and quality enhancement.

The University of Minnesota is under contract with the State to provide project participants with technical assistance and training in the following areas: (1) personal futures planning; (2) self-determination; and (3) organizational management and change. In addition, the university's Institute on Community Integration was awarded a 3-year contract to evaluate the performance-based contracting demonstration.

In September 1995, the State was awarded the section 1115 waivers needed to implement the demonstration. The planned implementation date is October 1, 1995.

95-094 Quality Assurance for Phase II of the Home Health Agency Prospective Payment Demonstration

Project No.:	500-95-0028
Period:	September 1995–September 2000
Funding:	$2,557,413
Award:	Contract
Principal Investigator:	Peter W. Shaughnessy, Ph.D.
Awardee:	Center for Health Policy Research 1355 South Colorado Boulevard Suite 306 Denver, CO 80222
HCFA Project Officer:	Phyllis A. Nagy Division of Aging and Disability

Description: This contract provides for developing and implementating a quality review mechanism for use by home health agencies (HHAs) participating in Phase II of the Home Health Agency Prospective Payment Demonstration. This demonstration is testing two alternative methods of paying HHAs on a prospective basis for services furnished under the Medicare program. The prospective payment approaches being tested include payments per visit by type of discipline (Phase I), and payments per episode of Medicare-covered home health care (Phase II). To ensure that incentives created under Phase I did not result in the provision of inadequate care to Medicare beneficiaries, the New England Research Institute, Inc. (NERI) implemented a quality assurance approach that utilized patient record reviews for a sample of Medicare beneficiaries. However, since one of the goals of HCFA's Medicare Home Health Initiative is to move toward the implementation of an outcome-based, patient-centered quality assurance system for Medicare home health, it was felt that the second phase

of this demonstration provided an opportunity to incorporate a scaled-down version of the outcome-based program developed by the Center for Health Services Research at the University of Colorado.

Status: The project was awarded in September 1995, and is in the early stages of development and implementation.

91-081 Quality Review for Phase I of the Home Health Agency Prospective Payment Demonstration

Project No.:	500-91-0096
Period:	September 1991–December 1994
Funding:	$ 1,499,085
Award:	Contract
Principal Investigator:	Alan Jette, Ph.D.
Awardee:	New England Research Institute, Inc. 9 Galen Street Watertown, MA 02172
HCFA Project Officer:	Phyllis A. Nagy Division of Aging and Disability
Mandate:	Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203)

Description: This contract involves quality review of the care provided by home health agencies (HHA) participating in the HHA Prospective Payment Demonstration. The demonstration is testing two alternative methods of paying HHAs on a prospective basis for services furnished under the Medicare program. The prospective payment approaches to be tested include payments per visit by type of discipline (Phase I) and payments per episode of Medicare-covered home health care (Phase II). To ensure that incentives created under Phase I do not result in the provision of inadequate care to Medicare beneficiaries, the awardee, New England Research Institute, Inc. (NERI), implemented a quality assurance approach that used patient record reviews for a pertinent sample of Medicare beneficiaries. If potential or actual problems were discovered, the awardee implemented a defined protocol to address the situation.

Status: During the initial year of the contract, NERI staff members completed all the activities related to the startup of the quality assurance plan, including baseline training for nurse reviewers. Throughout the demonstration period, NERI assessed patterns of problems within HHAs that required educational followup or additional medical reviews. The Phase I demonstration period was completed on September 30, 1994, and NERI submitted a final project report in March 1995. The report is currently under review.

92-034 Randomized Controlled Trial of Expanded Medical Care in Nursing Homes for Acute Care Episodes: Monroe County Longterm Care Program, Inc. (Formerly, A Randomized Controlled Trial of Expanded Medical Care in Nursing Homes for Acute Care Episodes)

Project No.:	95-C-90151/2
Period:	March 1992–August 1996
Funding:	$ 1,054,007
Award:	Cooperative Agreement
Principal Investigator:	Gerald Eggert, Ph.D.
Awardee:	Monroe County Longterm Care Program, Inc. 349 West Commercial Street, Suite 2250 Piano Works East Rochester, NY 14445
HCFA Project Officer:	Carolyn Rimes Division of Aging and Disability

Description: The objective of this demonstration is to develop, implement, and evaluate the effectiveness of expanded medical services to nursing home residents who are undergoing acute illnesses that would ordinarily require hospitalization. The intervention will include many services that are available in acute hospitals and are feasible and safe in nursing homes. These include an initial physician visit, all necessary followup visits, diagnostic and therapeutic services, and additional nursing care (including private duty), if necessary. The major goals are to reduce medical complications and dislocation trauma resulting from hospitalization and to save the expense of hospital care when patients could be managed safely in nursing homes with expanded services.

Status: Basic preparation for the implementation of the demonstration has been completed. Implementation is expected in August 1996.

94-131 Randomized Controlled Trial of Primary and Consumer-Directed Care for Persons with Chronic Illnesses

Project No.:	95-C-90467/2
Period:	September 1994–September 1997
Funding:	$ 345,243
Award:	Cooperative Agreement
Principal Investigator:	Gerald Eggert, Ph.D.
Awardee:	Monroe County Long Term Care Program, Inc. 349 West Commercial Street, Suite 2250 Piano Works East Rochester, NY 14445

HCFA Project Officer: Carolyn Rimes, Division of Aging and Disability

Description: This demonstration will assess differences in outcome for three treatment groups: a consumer-directed group, a case-managed service group, and a model that combines both treatment patterns. Findings will be compared with a control group that receives no additional services or benefits. Eligibility for participation is determined by residence in the community (at home or in an assisted living setting) and by Medicare coverage with a diagnosis of irreversible dementia or three or more limitations in activities of daily living. In addition, participants must be at risk for hospitalization (i.e., their participation is based on prior use of hospitals or emergency rooms).

Status: This project is in the development phase. Implementation is anticipated in August 1996.

93-035 Rehabilitating Medicare Beneficiaries at Home

Project No.: 95-C-90243/1
Period: April 1993–April 1994
Funding: $ 80,000
Award: Cooperative Agreement
Principal Investigator: Samuel Scialabba
Awardee: Wellmark Healthcare Services, Inc.
60 William Street
Wellesley, MA 02181
HCFA Project Officer: Stefan N. Miller, Division of Aging and Disability

Description: Wellmark intends to conduct a 2-year Medicare demonstration that will provide beneficiaries with acute rehabilitation services at home as an alternative to more expensive inpatient rehabilitation hospital services. The Health Care Financing Administration has awarded a cooperative agreement to Wellmark to further refine its project design to develop information on specific eligibility and screening criteria for patient enrollment, detailed cost data on the proposed service package, and informed consent policies to adequately inform patients and caregivers of the risks and responsibilities of rehabilitative home care. Medicare waivers will be required to allow Wellmark reimbursement as a prospective payment, system-exempt rehabilitation hospital. Funding for the evaluation will be provided by the Robert Wood Johnson Foundation as part of a national study entitled "Evaluation of Innovative Rehabilitation Alternatives and Critical Dimensions of Rehabilitative Care."

Status: The final report has been submitted. A request for Medicare waivers to implement the project is under review.

93-097 Regional Variation in Home Health Episode Length and Number of Visits Per Episode (Formerly, Long-Term Care Studies (Section 207))

Project No.: 500-89-0047/38
Period: July 1993–November 1994
Funding: $ 168,600
Award: Contract
Principal Investigator: David Kennell
Awardee: Lewin/VHI, Inc.
(See page 148)
HCFA Project Officer: Carolyn Rimes, Division of Aging and Disability

Description: This study focused on two questions: (1) Why does the use of home health care vary across the regions? (2) Is there a corresponding variation across the regions in patient outcomes suggesting that lower levels of care lead to poorer outcomes for patients, or that higher levels lead to improved outcomes? This study used the Medicare claims files, the provider of services file, the area resource file, and the Regional Home Health Intermediary database to determine the contribution of three sets of factors to regional variation. These sets of factors are patient characteristics, supply of home health agencies and staff, and availability of alternatives to home health care.

Status: The final report has been received and is being reviewed.

95-067 Rhode Island Long-Term Care Waiver: CHOICES

Project No.: 18-P-90655/1-01
Period: May 1995–May 1996
Funding: $ 150,000
Award: Grant
Principal Investigator: Christine C. Ferguson
Awardee: Rhode Island Department of Human Services
600 New London Avenue
Cranston, RI 02920
HCFA Project Officer: Thomas Theis, Division of Aging and Disability
Mandate: Title XIX, Section 1115

Description: In 1994, the State of Rhode Island Department of Human Services (DHS) and Department of Mental Health, Retardation and Hospitals (MHRH) submitted a waiver-only proposal which intends to consolidate all current State and Federal funding streams for approximately 4,000 adults with developmental disabilities under one managed care Title XIX

waiver program. The State proposed a 5-year demonstration with a two-phase transition process. The State wants to consolidate into a single program with a single set of rules the following separate Title XIX programs:

- Intermediate Care Facilities for the Mentally Retarded (ICF-MR).
- Home and Community Based Waiver.
- State Plan Rehabilitation Services.
- Acute/Medical Care.

Rhode Island envisions a publicly administered managed-care system with a single-payer model. Each eligible person will be enrolled in a private health maintenance organization or approved health plan for acute health care. Managed care plans participating in Rhode Island's RIte Care program may be asked to participate in the CHOICES program and provide managed health care for people with developmental disabilities, thus bringing together Rhode Island's two managed care initiatives. Alternatively, a statewide health care plan will be established for adults with developmental disabilities and the employees of the service agencies.

Under CHOICES, a case-management system will also be available to assist each eligible individual to obtain required long-term supports. The State intends to ascribe to all eligible persons a dollar amount with which they, with technical assistance from a broker or other source, will choose to manage the long-term care services directly themselves via a voucher, or choose an agency that can support a their needs within the identified resources available. This dollar amount will be based on a methodology prepared by the assessment/authorization work group.

Services covered by CHOICES can be divided into several categories:

- Supported living services.
- Alternative living arrangements.
- Day supports.
- Acute care/medical services.

The covered target population under CHOICES consists principally of persons with MR or related conditions, and the developmentally disabled, who are already eligible for and receiving services under various currently operating Title XIX programs.

In addition to its current population, CHOICES will serve up to 25 individuals with traumatic brain injury who are in need of long-term community living supports and who may be inappropriately institutionalized or living in the community with inadequate support; approximately 500 individuals now receiving supported employment services funded with State monies; about 40 people currently in the State-funded developmental disabilities program for whom there is no Federal financial participation; and approximately 125 people turning 21 and graduating from special education, applying for services from the Division of Developmental Disabilities under the Department of Human Services for Rhode Island.

Status: The State was awarded the grant by the Health Care Financing Administration in June 1995 to further develop the project design. Waivers have not yet been awarded. The special terms and conditions of the grant award were accepted by the State of Rhode Island DHS and the MHRH. Office of Research and Demonstrations/Division of Aging and Disability staff and Regional office staff members made a site visit to the project in early September. They met with the CHOICES Senior Management Team about the status of the CHOICES proposal and areas of concern including acute care, health plan choices, MMIS (Medicaid Management Information Systems), vouchers and payment, and Intermediate Care Facilities for the Mentally Retarded (ICF-MR) regulations. Each of five work groups provided overviews of where they were in developing information for the application. The Senior Management Team, in conjunction with the work groups, have made progress in developing information for the application. They anticipate submitting a revised application soon.

95-091 Second Generation of Social Health Maintenance Organization Demonstration

Project No.:	95-C-90501/4-01
Period:	January 1995–January 1996
Funding:	$150,000
Award:	Cooperative Agreement
Principal Investigator:	JoAnne Dutcher CAC Ramsey Health Plan 75 Valencia Avenue Coral Gables, FL 33134
HCFA Project Officer:	Melissa S. McNiff, MPS Division of Aging and Disability
Mandate:	Omnibus Budget Reconciliation Act of 1990

Description: In accordance with section 2355 of Public Law 98-369, the concept of a social health maintenance organization (S/HMO) was developed and implemented. The S/HMO integrates health and social services under the direct financial management of the provider of services. All acute and long-term care services are provided by or through the S/HMO at a fixed, annual, prepaid capitation sum. The Omnibus Budget Reconciliation Act of 1990 authorized the expansion of the Social Health Maintenance Organization demonstration. The purpose of this second-generation S/HMO (S/HMO-II) demonstration is to refine the targeting and financing methodologies and the benefit design of the current S/HMO model. The S/HMO-II model should also provide an opportunity to test more geriatrically

oriented models of care. The purpose of the grant funding is to assist awardees in developmental activities required to implement an S/HMO-II demonstration. Six sites were awarded developmental grants.

Status: The S/HMO-II project is in the preimplementation phase.

95-085 Second Generation Social Health Maintenance Organization Demonstration: California

Project No.:	95-C-90493/9-01
Period:	January 1995–January 1996
Funding:	$150,000
Award:	Cooperative Agreement
Principal Investigator:	Bobbi Baron Contra Costa County Health Plan 595 Center Avenue, Suite 100 Martinez, CA 94553
HCFA Project Officer:	Dennis M. Nugent Division of Aging and Disability
Mandate:	Section 4027(b)(4) of the Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: In accordance with section 2355 of Public Law 98-369, the concept of a social health maintenance organization (S/HMO) was developed and implemented. The S/HMO integrates health and social services under the direct financial management of the provider of services. All acute and long-term care services are provided by or through the S/HMO at a fixed, annual, prepaid capitation sum. The Omnibus Budget Reconciliation Act of 1990 authorized the expansion of the Social Health Maintenance Organization demonstration. The purpose of this second-generation S/HMO (S/HMO-II) demonstration is to refine the targeting and financing methodologies and the benefit design of the current S/HMO model. The S/HMO-II model should also provide an opportunity to test more geriatrically oriented models of care. The purpose of the grant funding is to assist awardees in developmental activities required to implement an S/HMO-II demonstration. Six sites were awarded developmental grants.

Status: The S/HMO-II project is in the preimplementation phase.

95-090 Second Generation of Social Health Maintenance Organization Demonstration: Colorado

Project No.:	95-C-90498/8-01
Period:	January 1995–January 1996
Funding:	$150,000
Award:	Cooperative Agreement
Principal Investigator:	Earl Elicker Rocky Mountain Health Maintenance Organization 2775 Crossroads Boulevard Grand Junction, CO 81506
HCFA Project Officer:	Melissa S. McNiff, MPS Division of Aging and Disability
Mandate:	Omnibus Budget Reconciliation Act of 1990

Description: In accordance with section 2355 of Public Law 98-369, the concept of a social health maintenance organization (S/HMO) was developed and implemented. The S/HMO integrates health and social services under the direct financial management of the provider of services. All acute and long-term care services are provided by or through the S/HMO at a fixed, annual, prepaid capitation sum. The Omnibus Budget Reconciliation Act of 1990 authorized the expansion of the Social Health Maintenance Organization demonstration. The purpose of this second-generation S/HMO (S/HMO-II) demonstration is to refine the targeting and financing methodologies and the benefit design of the current S/HMO model. The S/HMO-II model should also provide an opportunity to test more geriatrically oriented models of care. The purpose of the grant funding is to assist awardees in developmental activities required to implement an S/HMO-II demonstration. Six sites were awarded developmental grants.

Status: The S/HMO-II project is in the preimplementation phase.

95-086 Second Generation Social Health Maintenance Organization Demonstration: Maine

Project No.:	95-C-90496/1-01
Period:	January 1995–January 1996
Funding:	$150,000
Award:	Cooperative Agreement
Principal Investigator:	Molly Zelley Fallon Community Health Plan Chestnut Place 10 Chestnut Street Worcester, MA 01608

HCFA Project Officer: Dennis M. Nugent
Division of Aging and Disability

Mandate: Section 4027(b)(4) of the Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: In accordance with section 2355 of Public Law 98-369, the concept of a social health maintenance organization (S/HMO) was developed and implemented. The S/HMO integrates health and social services under the direct financial management of the provider of services. All acute and long-term care services are provided by or through the S/HMO at a fixed, annual, prepaid capitation sum. The Omnibus Budget Reconciliation Act of 1990 authorized the expansion of the Social Health Maintenance Organization demonstration. The purpose of this second-generation S/HMO (S/HMO-II) demonstration is to refine the targeting and financing methodologies and the benefit design of the current S/HMO model. The S/HMO-II model should also provide an opportunity to test more geriatrically oriented models of care. The purpose of the grant funding is to assist awardees in developmental activities required to implement an S/HMO-II demonstration. Six sites were awarded developmental grants.

Status: The S/HMO-II project is in the preimplementation phase.

95-088 Second Generation Social Health Maintenance Organization Demonstration: Nevada

Project No.: 95-C-90503/9-01
Period: January 1995–January 1996
Funding: $150,000
Award: Cooperative Agreement
Principal Investigator: Bonnie Hillegass
Health Plan of Nevada, Inc.
P.O. Box 15645
Las Vegas, NV 89114
HCFA Project Officer: Dennis M. Nugent
Division of Aging and Disability

Mandate: Section 4027(b)(4) of the Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: In accordance with section 2355 of Public Law 98-369, the concept of a social health maintenance organization (S/HMO) was developed and implemented. The S/HMO integrates health and social services under the direct financial management of the provider of services. All acute and long-term care services are provided by or through the S/HMO at a fixed, annual, prepaid capitation sum. The Omnibus Budget Reconciliation Act of 1990 authorized the expansion of the Social Health Maintenance Organization demonstration. The purpose of this second-generation S/HMO (S/HMO-II) demonstration is to refine the targeting and financing methodologies and the benefit design of the current S/HMO model. The S/HMO-II model should also provide an opportunity to test more geriatrically oriented models of care. The purpose of the grant funding is to assist awardees in developmental activities required to implement an S/HMO-II demonstration. Six sites were awarded developmental grants.

Status: The S/HMO-II project is in the preimplementation phase.

95-087 Second Generation Social Health Maintenance Organization Demonstration: South Carolina

Project No.: 95-C-90500/4-01
Period: January 1995–January 1996
Funding: $150,000
Award: Cooperative Agreement
Principal Investigator: Thomas Brown
Richland Memorial Hospital
Five Richland Medical Park
Columbia, SC 29203
HCFA Project Officer: Dennis M. Nugent
Division of Aging and Disability
Mandate: Section 4027(b)(4) of the Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: In accordance with section 2355 of Public Law 98-369, the concept of a social health maintenance organization (S/HMO) was developed and implemented. The S/HMO integrates health and social services under the direct financial management of the provider of services. All acute and long-term care services are provided by or through the S/HMO at a fixed annual prepaid capitation sum. The Omnibus Budget Reconciliation Act of 1990 authorized the expansion of the Social Health Maintenance Organization demonstration. The purpose of this second-generation S/HMO (S/HMO-II) demonstration is to refine the targeting and financing methodologies and the benefit design of the current S/HMO model. The S/HMO-II model should also provide an opportunity to test more geriatrically oriented models of care. The purpose of the grant funding is to assist awardees in developmental activities required to implement an S/HMO-II demonstration. Six sites were awarded developmental grants.

Status: The S/HMO-II project is in the preimplementation phase.

94-043 Simulations of Skilled Nursing Facility Payment Options

Project No.:	500-89-0047/44
Period:	January 1994–November 1994
Funding:	$ 79,200
Award:	Contract
Principal Investigator:	David Kennell
Awardee:	Lewin/VHI, Inc. (See page 148)
HCFA Project Officer:	Carolyn Rimes Division of Aging and Disability

Description: This project, conducted in collaboration with the Health Care Financing Administration (HCFA), produces impact estimates for different payment options for the Medicare skilled nursing facility (SNF) benefit. The impacts of alternative SNF payment options are estimated with the use of The Urban Institute's SNF simulation model. This project uses recent 1990–91 SNF cost reports as input data for the simulation model and estimates the distributional effects of various prospective payment options received from HCFA. This work has been subcontracted to the Urban Institute.

Status: This project has been completed.

93-078 Site Development and Technical Assistance for the Second Generation Social Health Maintenance Organization Demonstration

Project No.:	500-93-0033
Period:	September 1993–January 1998
Funding:	$ 1,777,189
Award:	Contract
Principal Investigator:	Robert L. Kane, M.D.
Awardee:	University of Minnesota School of Public Health Institute for Health Services Research D-351 Mayo Memorial Building 420 Delaware Street, SE., Box 197 Minneapolis, MN 55455-0392
HCFA Project Officer:	Dennis M. Nugent Division of Aging and Disability
Mandate:	Section 4027(b)(4) of the Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)

Description: The second-generation Social Health Maintenance Organization (S/HMO-II) demonstration is scheduled to be implemented in fiscal year 1996. The purpose of this project is to refine the targeting and financing methodologies and the benefit design of the current S/HMO demonstration. Six organizations were selected to participate in the project. The development phase of the demonstration began in January 1995. Under this contract, the University of Minnesota and its subcontractor, the University of California, San Francisco, are providing technical assistance in the development, implementation, and operation of the second-generation project and assisted in the demonstration's site selection process. The participating organizations will provide a wide range of services to meet both acute and long-term care needs of Medicare and Medicaid beneficiaries. One of the distinguishing characteristics of the second generation model is a greater emphasis on geriatric care.

Status: The development phase of the S/HMO-II demonstration began in January 1995. During this time, the project's risk-adjusted payment methodology was developed. The case management and geriatric protocols to be used by the demonstration sites to identify a beneficiary's care needs were also completed. The University of Minnesota and the University of California at San Francisco, will continue to provide technical assistance and support throughout the project.

84-004 Social Health Maintenance Organization Project for Long-Term Care: Elderplan, Inc.
(Formerly, Social Health Maintenance Organization Project for Long-Term Care)

Project No.:	95-P-09101/2
Period:	August 1984–December 1997
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Eli Feldman
Awardee:	Elderplan, Inc. 6323 Seventh Avenue Brooklyn, NY 11220
HCFA Project Officer:	Thomas Theis Division of Aging and Disability
Mandates:	Deficit Reduction Act of 1984 (Public Law 98-369) Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508) Omnibus Budget Reconciliation Act of 1993 (Public Law 103-66)

Description: In accordance with section 2355 of Public Law 98-369, this project was developed to implement the concept of a social health maintenance organization (S/HMO) for acute and long-term care. A S/HMO integrates health and social services under the direct financial management of the provider of services. All services are provided by or through the S/HMO at a fixed, annual,

prepaid capitation sum. Four demonstration sites were selected to participate; of the four, two were health maintenance organizations that have added long-term care services to their existing service packages and two were long-term care providers that have added acute care service packages. Elderplan is one of the long-term care provider sites that developed and added an acute care service component. HealthPartners (formerly Group Health in Minneapolis-St. Paul, Minnesota), one of the original sites, discontinued participation on January 1, 1995.

Status: Elderplan implemented its service delivery network in March 1985. Elderplan uses both Medicare and Medicaid waivers. During the first 30 months of operation, Federal and State Governments shared financial risk with the sites. This risk sharing ended August 31, 1987. On three separate occasions, this demonstration has been extended by legislation. Current legislation (Public Law 103-66) extends the demonstration period through December 31, 1997.

84-006 **Social Health Maintenance Organization Project for Long-Term Care: Kaiser Permanente Center for Health Research** (Formerly, Social Health Maintenance Organization Project for Long-Term Care)

Project No.:	95-P-09103/0
Period:	August 1984–December 1997
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Lucy Nonnenkamp
Awardee:	Kaiser Permanente Center for Health Research 3800 North Kaiser Center Drive Portland, OR 97227-1098
HCFA Project Officer:	Thomas Theis Division of Aging and Disability
Mandates:	Deficit Reduction Act of 1984 (Public Law 98-369) Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508) Omnibus Budget Reconciliation Act of 1993 (Public Law 103-66)

Description: In accordance with section 2355 of Public Law 98-369, this project was developed to implement the concept of a social health maintenance organization (S/HMO) for acute and long-term care. A S/HMO integrates health and social services under the direct financial management of the provider of services. All services are provided by or through the S/HMO at a fixed, annual, prepaid capitation sum. Four sites were selected to participate; of the four, two were health maintenance organizations (HMOs) that have added long-term care services to their existing service packages and two were long-term care providers that have added acute care service packages. Kaiser Permanente Center for Health Research (doing business as Medicare Plus II) is one of the HMO sites that developed and added a long-term care component to its service package. HealthPartners (formerly Group Health in Minneapolis-St. Paul, Minnesota), one of the original sites, discontinued participation on January 1, 1995.

Status: Medicare Plus II implemented its service delivery network in March 1985. Medicare Plus II uses Medicare waivers only. During the first 30 months of operation, the Federal Government shared financial risk with the Oregon site. This risk sharing ended August 31, 1987. On three separate occasions, this demonstration has been extended by legislation. Current legislation (Public Law 103-66) extends the demonstration period through December 31, 1997.

84-007 **Social Health Maintenance Organization Project for Long-Term Care: SCAN Health Plan** (Formerly, Social Health Maintenance Organization Project for Long-Term Care)

Project No.:	95-P-09104/9
Period:	August 1984–December 1997
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Sam Ervin
Awardee:	SCAN Health Plan 521 East Fourth Street Long Beach, CA 90802
HCFA Project Officer:	Thomas Theis Division of Aging and Disability
Mandates:	Deficit Reduction Act of 1984 (Public Law 98-369) Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508) Omnibus Budget Reconciliation Act of 1993 (Public Law 103-66)

Description: In accordance with section 2355 of Public Law 98-369, this project was developed to implement the concept of a social health maintenance organization (S/HMO) for acute and long-term care. An S/HMO integrates health and social services under the direct financial management of the provider of services. All services are provided by or through the S/HMO at a fixed, annual, prepaid capitation sum. Four sites were selected to participate; of the four, two were health maintenance organizations that have added long-term care services to their existing service packages and two were long-term care providers that have added acute care service packages.

SCAN Health Plan is one of the long-term care provider sites that developed and added an acute care service component. HealthPartners (formerly Group Health in Minneapolis-St. Paul, Minnesota), one of the original sites, discontinued participation on January 1, 1995.

Status: SCAN Health Plan implemented its service delivery network in March 1985. SCAN Health Plan utilizes both Medicare and Medicaid waivers. During the first 30 months of operation, Federal and State Governments shared financial risk with the sites. This risk sharing ended August 31, 1987. On three separate occasions, this demonstration has been extended by legislation. Current legislation (Public Law 103-66) extends the demonstration period through December 31, 1997.

92-048 Sources of Medicare Home Health Expenditure Growth: Implications for Control Options

Project No.:	17-C-90107/1
Period:	February 1992–December 1995
Funding:	$210,706
Award:	Cooperative Agreement
Principal Investigator:	Christine Bishop, Ph.D.
Awardee:	Brandeis University Heller Graduate School Institute for Health Policy 415 South Street P.O. Box 9110 Waltham, MA 02254-9110
HCFA Project Officer:	J. Donald Sherwood Division of Payment Systems

Description: The overall objective of the project is to develop and consider options for restraining home health expenditure growth. The project has two phases. First is to use secondary data to examine the composition of Medicare home health expenditure growth between 1985 and 1989 and 1989 to 1991 to attribute total growth to growth in persons served, visits per person, mix of visits, and visit charges; and to attribute growth to types of agencies by auspice and scale. Second is to examine data from the Regional Home Health Intermediary database to measure variation in types of patients served at intake, and the characteristics of high-use patients, by auspice and region, and to consider differences in mix and intensity of services provided.

Status: The first phase has been completed, resulting in an overview entitled "Recent Growth in Medicare Home Health: Sources and Implications." An edited version of this analysis, "Recent Growth of Medicare Home Health," by Christine Bishop, Ph.D., and Kathleen Carley Skwara, was published in *Health Affairs*, 12(3):95–110, Fall 1993. The second phase will be completed by December 1995.

92-026 Special Care Managed Care Initiative

Project No.:	18-C-90127/5
Period:	February 1992–July 1996
Funding:	$656,270
Award:	Cooperative Agreement
Principal Investigator:	Howard Garber, Ph.D.
Awardee:	Wisconsin State Department of Health and Social Services 1 West Wilson Street P.O. Box 309 Madison, WI 53701-0309
HCFA Project Officer:	Samuel L. Brown Division of Aging and Disability

Description: The purpose of the special care initiative project is to gain improved understanding of the need, use, and cost of delivery of health services to high-risk, severely disabled persons. The severely disabled population is a significant user of medical services. Moreover, cost between 1988 and 1991 increased at a rate double that of population increase. Therefore, an important objective is to contain the cost and use of Medicaid services by severely disabled persons, while maintaining or improving the level of client satisfaction. Special Care, Inc. (SCI) is an independent, nonprofit organization that represents a joint venture between the Milwaukee Center for Independence, a Milwaukee rehabilitation facility, and the Wisconsin Health Organization, an established health maintenance organization. SCI will create specialized services, including a dedicated physician panel, case management services, and clinical services as strategies to assess medical need and to better coordinate service resources available in the community. The State of Wisconsin will use a capitation methodology for reimbursement to SCI. Enrollment of SCI members will be voluntary. As a research and demonstration program, it aims to improve the understanding of the need, use, costs, and cost management opportunities associated with the delivery of health services to high-risk, severely disabled persons. These individuals are disabled, categorically needy, noninstitutionalized, exempt from the spenddown provisions, eligible for Medicaid, and eligible for Supplemental Security Income disability benefits. The diagnostic distribution of cases in this population is 41 percent mental retardation, 17.4 percent chronic mental illness, 13.5 percent skeletal/muscular, 11.2 percent epilepsy, 9.3 percent cerebral palsy, 1.6 percent cardiac/circulatory, 1.2 percent autism, and 4.9 percent other. This is a severely disabled and generally unemployable population whose medical care use and cost experience show a non-normalized pattern. The average hospital length of stay for members of this group is 7 times longer than that for the general population. Their hospital costs are 4 times higher—without clear explanation. To measure the performance of the SCI program, a management information system (MIS) file will be created to match the demographic characteristics of program participants with the cost and use data obtained from the

history files maintained by the Wisconsin Medicaid program. Medicaid data will include service and procedure frequencies, service mix, billings and reimbursements, provider practices, and certain medical status indicators. MIS files will contribute additional information on disability condition, enrollment information, benefit coordination, and case management. In addition, data on client satisfaction, quality of care, and enrollment/disenrollment decisions will be collected.

Status: The State is operating this project under a section 1915(a) State Plan exception. The program officially began in June 1994. As a point of clarification, Special Care signifies the initiative proposed to the Health Care Financing Administration (HCFA) for the managed care program, while Independent Care (I Care) is the formal community name of the managed care company.

Enrollment in the I Care program is now greater than 2,000 and is quickly approaching the 3,000 mark. Preliminary observations indicate a stable and comprehensive provider system in place, support of advocates, a positive impact on patient quality of care, and cost management strategies resulting in efficiencies.

The evaluation contract with the Human Services Research Institute (HSRI) was signed in May 1994 after it was reviewed and approved by the HCFA project officer. This evaluation contractor submitted its final working plan at the beginning of grant year 03. HSRI proposes a 3-year evaluation, which will combine survey data with HCFA's Medicaid Statistical Information System Administrative files.

The evaluator developed and piloted an interview protocol, the Cross-Disability Integrated Health Outcomes Survey for use with the I Care recipients and control group members. Upon approval of the survey instrument by the project's principal investigator, Dr. Howard Garber, field surveyers will be secured through a subcontract with the University of Wisconsin Survey Institute.

Evaluation activities will include the selection of comparison groups, using cost cluster information from a State-developed profile of a sample of I Care patients. This sample was drawn from an aggregate of all 1994 paid claims for every Milwaukee and Racine county Supplemental Security Income beneficiary who is disabled and was then assigned to one of three cost categories—low, medium, or high.

95-089 State of Minnesota "Long-Term Care Options Project (LTCOP)"

Project No.:	11-W-00024/5
Period:	April 1995–December 2000 (yearly continuation)
Funding:	Waiver only
Award:	Grant
Principal Investigator:	Pamela Parker
Awardee:	Minnesota Department of Human Services Human Services Building 444 Lafayette Road St. Paul, MN 55155
HCFA Project Officer:	Melissa S. McNiff, MPS Division of Aging and Disability
Mandates:	Section 1115 of the Social Security Act and Section 402 of the 1967 Amendments to the Social Security Act

Description: In April 1995, the State of Minnesota was awarded Medicare and Medicaid waivers for a 5-year demonstration designed to test delivery systems that integrate long-term care and acute care services for elderly dual eligibles. The State is targeting the elderly dually entitled population that resides in the seven-county metro area and St. Louis county. Elderly Medicaid eligibles now required to enroll in the State's current section 1115 Prepaid Medical Assistance Program (PMAP) demonstration will be given the option to enroll in Long-Term Care Options Project (LTCOP), which in essence adds long-term care and Medicare benefits to basic PMAP benefits. Under this demonstration, the State will be treated as a health plan that contracts with Health Care Financing Administration to provide services, and provides those services through subcontracts with various appropriate providers. The State will continue its current administration of the Medicaid-managed care program while incorporating some Medicare requirements that apply directly to the health plans with which the State would subcontract for LTCOP. HCFA's direct oversight functions would continue to apply to the overall demonstration and managing entity, which would be the State.

Status: The LTCOP project is in the preimplementation phase.

92-102 State Responses to Medicaid Estate Planning (Formerly, Long-Term Care Studies (Section 207))

Project No.:	500-89-0047/36
Period:	May 1992–May 1993
Funding:	$41,000
Award:	Contract
Principal Investigator:	David Kennell
Awardee:	Lewin/VHI, Inc. (See page 148)
HCFA Project Officer:	Carolyn Rimes Division of Aging and Disability

Description: The purpose of this report is to provide readers with an overview of recent State initiatives regarding Medicaid estate planning. Data for the report were collected primarily through telephone interviews with key personnel at Medicaid eligibility offices in 26 States. In those States where initiatives were under way, copies of recent legislation, regulations, task force reports, internal memoranda, and other documents were obtained and reviewed. This project was completed by SysteMetrics/ MedStat under subcontract to Lewin/VHI, Inc.

Status: The study found that many States are attempting to place limitations on asset transfers in an effort to restrict Medicaid estate-planning practices. Furthermore, States have expressed a strong desire for Federal clarification on Medicaid transfer-of-asset provisions and want additional Federal legislation that further restricts the transfer of assets. The final report has been received and is currently under review.

91-098 **Synthesis of Financing and Delivery of Long-Term Care for the Disabled Nonelderly** (Formerly, Long-Term Care Studies (Section 207))

Project No.:	500-89-0047/30
Period:	June 1991–December 1995
Funding:	$ 30,000
Award:	Contract
Principal Investigator:	David Kennell
Awardee:	Lewin/VHI, Inc. 9302 Lee Highway, Suite 500 Fairfax, VA 22031-1207
HCFA Project Officer:	Carolyn Rimes Division of Disability and Aging

Description: This study synthesizes the current literature and information from various data sources on the financing and delivery of long-term care for the disabled nonelderly. This study also summarizes the current knowledge of demographic and economic characteristics of the disabled nonelderly, types of services and patterns of service use by the disabled nonelderly, how these services for the disabled nonelderly are paid, and other unique issues related to the disabled nonelderly. This work was completed by Joshua Wiener of The Brookings Institution under subcontract to Lewin/VHI, Inc.

Status: The final report has been received and is currently under review. The findings will be published in the conference proceedings from the Brookings Institution.

91-099 **Synthesis of Literature on Effectiveness of Special Assistive Devices in Managing Functional Impairment** (Formerly, Long-Term-Care Studies (Section 207))

Project No.:	500-89-0047/28
Period:	August 1991–January 1996
Funding:	$ 32,600
Award:	Contract
Principal Investigator:	David Kennell
Awardee:	Lewin/VHI, Inc. (See page 148)
HCFA Project Officer:	Carolyn Rimes Division of Aging and Disability

Description: This synthesis has two components. The first is a description of the special assistive devices and a summary of how these devices are paid for under the current system. The second is a summary of the effectiveness of special assistive devices in managing functional impairments. This synthesis also discusses various policy options, which relate to alternative financing arrangements for special assistive devices. The analysis of assistive device usage is obtained using the 1984 Supplement on Aging and the 1990 National Health Interview Survey Supplement on Assistive Devices.

Status: This first draft has been received and is expected to be completed in January 1996.

91-100 **Synthesis of Literature on Targeting to Reduce Hospital Use** (Formerly, Long-Term-Care Studies (Section 207))

Project No.:	500-89-0047/5
Period:	September 1991–August 1995
Funding:	$ 30,000
Award:	Contract
Principal Investigator:	David Kennell
Awardee:	Lewin/VHI, Inc. (See page 148)
HCFA Project Officer:	Carolyn Rimes Division of Aging and Disability

Description: This study synthesizes the literature on targeting across a variety of types of programs, all of which have the goal of reducing hospital use. These programs include geriatric evaluation units, nursing home staffing enhancement programs, and hospital-based programs for discharge planning and transitional case management. Although targeting is an issue for all of these types of programs, little attention has been given to evaluating targeting criteria. This project has been subcontracted to Mathematica Policy Research, Inc.

Status: This review of the literature points to the all-too-familiar gaps in the current health care system. They include the lack of overall coordination and monitoring of care for the elderly, an insufficient level of primary and acute care for nursing home patients, poor access to a range of subacute services, a shortage of physicians with geriatric training for community-dwelling elderly persons, and insufficient efforts to reduce the highest cost diseases and complications that arise during hospitalization. The literature also suggests that several groups of elderly might benefit from such interventions as comprehensive geriatric assessment, enhanced hospital discharge planning, and the social health maintenance organization. These groups include individuals whose conditions are difficult to stabilize or who require regimens of medications or diet that must be monitored for compliance or change, individuals for whom medications are likely to lead to adverse events, and individuals facing nursing home placement without first being evaluated for rehabilitative potential. The final report has been received and is being reviewed.

91-103 **Synthesis of Reimbursement Options** (Formerly, Long-Term-Care Studies (Section 207))

Project No.:	500-89-0047/10
Period:	September 1991–January 1996
Funding:	$ 77,600
Award:	Contract
Principal Investigator:	David Kennell
Awardee:	Lewin/VHI, Inc. 9302 Lee Highway, Suite 500 Fairfax, VA 22031-1207
HCFA Project Officer:	Carolyn Rimes Division of Aging and Disability

Description: The purpose of this synthesis is to assist the Health Care Financing Administration and other relevant policymakers in answering specific questions concerning nursing home reimbursement. The first part of the synthesis is organized into four sections: summary, overview of the Medicaid reimbursement system and State policy goals, design of the details of a reimbursement system, and analysis of options for captal reimbursement. The second part is organized into two sections:

- Synthesis of research studies relevant to modifying the current method by which skilled nursing facilities (SNF) receive payment under Part A of the Medicare program.
- Synthesis of research studies relevant to replacing the current system with a system under which Medicare SNF payment would be made on the basis of prospectively determined rates.

Status: This report is in draft. The report is expected to be completed in January 1996.

91-101 **Synthesis of the Nursing Home Bed Supply** (Formerly, Long-Term-Care Studies (Section 207))

Project No.:	500-89-0047/23
Period:	May 1991–September 1994
Funding:	$ 49,000
Award:	Contract
Principal Investigator:	David Kennell
Awardee:	Lewin/VHI, Inc. (See page 148)
HCFA Project Officer:	Carolyn Rimes Division of Aging and Disability

Description: Analyses have shown that there is excess demand for nursing home care. Part of this excess demand is attributed to State-imposed constraints on the supply of nursing home beds. States have imposed these supply constraints in an attempt to control their Medicaid budgets and to redirect resources from institutional to noninstitutional care. This synthesis addresses the following:

- How much variation is there in the supply of nursing home beds?
- Why do variations in the supply of beds exist across States?
- To what extent does a State's capital reimbursement system encourage/discourage sufficient investment of capital to meet its demand for new beds?
- What is the relationship between certificate of need and capital replacement?
- What is "excess demand" and how is it measured?

Status: This report found that much of the attention paid to the adequacy of a State's supply of nursing home beds focuses on the effect that supply has on access to care and often ignores important demand-side issues. One of these issues, the subsidization of health care expenses for Medicaid beneficiaries, results in excess demand for nursing home services by Medicaid beneficiaries, who are encouraged to demand more services than they otherwise would. This study found that, in general, access problems do not exist for private patients. However, access problems do exist for some Medicaid beneficiaries, especially for heavy-care persons with head injuries, with behavioral problems, or who need ventilators. Since each State has a unique long-term care system, measures of the adequacy of the supply of nursing home beds in one State may not accurately measure the adequacy of supply in another State. Furthermore, given the differences in programs, laws, and market conditions across States, policies that help control long-term care expenses in one State may not necessarily be appropriate for other States. The final report has been received and is being reviewed.

91-102 Synthesis of Unmet Need for Long-Term Care Services (Formerly, Long-Term Care Studies (Section 207))

Project No.:	500-89-0047/29
Period:	June 1991–August 1995
Funding:	$27,400
Award:	Contract
Principal Investigator:	David Kennell
Awardee:	Lewin/VHI, Inc. (See page 148)
HCFA Project Officer:	Carolyn Rimes Division of Aging and Disability

Description: The purpose of this study is to conduct a literature review and prepare a synthesis of previous work in the area of unmet need for long-term care services. This project concentrated on identifying unmet need using secondary analysis of survey data. Included is an analysis of data from the National Long-Term Care Surveys, the 1984 Supplement on Aging, the Longitudinal Study of Aging, and the Channeling demonstration projects. This study explores possible measures that can be constructed from national databases to assess unmet need for long-term care services. The study evaluates the merits of alternative measures, establishes definitions of unmet need, using survey data, and then develops a framework for comparing this analytic work with earlier studies. This work was completed by Barbara Lyons of the Johns Hopkins University School of Hygiene and Public Health under subcontract to Lewin/VHI, Inc.

Status: The final report has been received and is being reviewed.

91-056 Testing the Predictive Validity of Using Medicare Claims Data to Target High-Cost Patients

Project No.:	99-C-98526/1
Period:	August 1991–July 1993
Funding:	$139,898
Award:	Cooperative Agreement
Principal Investigator:	Christine Bishop, Ph.D.
Awardee:	Brandeis University Heller Graduate School Institute for Health Policy 415 South Street, P.O. Box 9110 Waltham, MA 02254-9110
HCFA Project Officer:	Phyllis A. Nagy Division of Aging and Disability

Description: For this study, Brandeis investigated the feasibility of using historical Medicare claims data of patients hospitalized with certain primary diagnoses to identify a subset of patients who are more likely to incur high levels of Medicare reimbursements in the future. Analysis was restricted to a sample of hospital patients with selected illnesses where past research indicates that the specific patient diagnosis eventually results in higher Medicare costs, and it is determined that targeted case management or coordinated care programs can be potentially effective (based on research and/or professional clinical judgment) in reducing overall health care costs.

Status: Although the preliminary study design was completed in a timely manner, development of an analytic research file was delayed. The final report has been received and is currently under review.

92-028 Texas Medicare Nursing Home Case-Mix and Quality Demonstration

Project No.:	95-C-90019/6
Period:	February 1992–December 1998
Funding:	$307,382
Award:	Cooperative Agreement
Principal Investigator:	Stephen Lorenzen, Ph.D.
Awardee:	Texas Department of Human Services P.O. Box 149030 (MC-E-601) Austin, TX 78714-9030
HCFA Project Officer:	Elizabeth S. Cornelius Division of Payment Systems

Description: Texas will participate in the multistate Nursing Home Case-Mix and Quality (NHCMQ) Demonstration. The objective of the demonstration is to test the feasibility and cost effectiveness of a case-mix payment system for nursing facility services under the Medicare and Medicaid programs that are based on a common patient classification system. The addition of Texas enhances the Health Care Financing Administration's ability to project the results of the demonstration on a national basis. Texas represents a western pattern of service using more proprietary multistate chain providers than is the pattern used in the East. Twenty Texas Medicare facilities were part of the original data collection for the development of the resource utilization group (RUG) III system. Texas has the second largest number of hospital-based facilities in the country. There are more than 20 metropolitan statistical areas of varying size. In addition, the State has a large number of rural areas. The State was traditionally a flat-rate intermediate care facility Medicaid system until 1989, when it implemented a RUG-type Medicaid payment system. This RUG-type payment system makes Texas well suited for inclusion in the Medicare portion of the demonstration.

Status: During the first year of participation, the Texas Department of Human Services worked with the Texas Department of Health to change the resident assessment instrument being used in the State. In April 1993, Texas implemented the minimum data set plus statewide as its resident assessment instrument. Analyses of 1990 Medicare Cost Report data, Medicare provider analysis and review Part A skilled nursing facility stay data, and the Texas Client Assessment and Review Evaluation (CARE) data have been conducted for use in developing the demonstration's

Medicare case-mix payment system. Under the Medicaid demonstration, Texas began development of the Quality Evaluation System of Texas, a resident characteristic information and reporting system using the CARE instrument. During the first year, the staff continued the development and enhancement of the system, which was codified into law by the Texas Legislature in summer 1993. They now are producing facility-level reports with statewide comparisons for Texas providers on a twice-a-year basis. The Medicare portion of the NHCMQ demonstration was implemented July 1, 1995, in Texas.

87-009 **Texas Nursing Home Case-Mix Demonstration**

Project No.:	11-C-99131/6
Period:	September 1987–April 1994
Funding:	$ 532,830
Award:	Cooperative Agreement
Principal Investigator:	Ken C. Stedman
Awardee:	Texas Department of Human Services P.O. Box 149030 (MC-E-601) Austin, TX 78714-9030
HCFA Project Officer:	Elizabeth S. Cornelius Division of Payment Systems

Description: This Texas Department of Human Services' project had two parts. First was to develop, implement, and evaluate a Medicaid prospective case-mix payment system. The payment system is based on feasibility studies sponsored by the Health Care Financing Administration. The major Medicaid objectives of this part were to match payment rates to resident need, promote the admission of heavy-care patients to nursing homes, provide incentives to improve quality of care, improve management practices, and demonstrate the administrative feasibility of the new system. Second was to develop and pilot test a case-mix-adjusted prospective payment system (PPS) for Medicare patients in skilled nursing facilities. The objective of the Medicare pilot test was to develop and implement the administrative processes for a Medicare PPS in three facilities, based on a resource utilization group (RUG) classification. The index that was used for the classification of Medicare patients was the RUG-T18, which uses the same clinical groups and the activities of daily living (ADL) scale used in the New York Resource Utilization Group, Version II (RUG II) system. The difference occurs in the expanded rehabilitation groups for Medicare patients. Texas used a quasi-experimental design for the Medicare pilot test to compare the effect of introducing case-mix payment in a small group of experimental facilities in one catchment area versus continuing the flat-rate, cost-based system in a control catchment area. The State used a pre/postdesign for the Medicaid system. Case-mix classifications are based on a review of six different systems in which the New York RUG II explained the greatest variance of staff time. Case-mix indexes borrow major elements of the RUG II system and some of the rationale from the Minnesota system. The Texas index of level of effort (TILE) uses four clinical groups to form clusters and to develop subgroups using an ADL scale. A quality of care information and reporting system called The Quality Evaluation System of Texas (QUEST) was developed and tested. Two third-party evaluations were completed: one on data reliability and one on the validity of the data analysis methods.

Status: During the first year, the TILE and RUG-T18 indexes were reviewed for compatibility. The Medicaid payment system became operational statewide under the Texas Medicaid State plan in April 1989. As of the end of the Medicaid part in Fall 1992, over 102,000 Medicaid recipients had been a part of the demonstration. An evaluation database consisting of the Medicaid Client Assessment, Review, and Evaluation claims documents for the 102,000 recipients with at least three assessments was used for the evaluation. Medicare waivers were approved, and the Medicare pilot test was implemented in 3 Austin area nursing homes in November 1992 for a period of 18 months. At the time of their 1991 Federal certification survey, the pilot-tested facilities had 59 Medicare Part A-covered residents. Cost analyses of both national and State samples of Medicare providers were performed to arrive at baseline costs for calculating the rates for the RUG-T18 groups. The resident assessment instrument, the minimum data set plus, that was developed for the Multi-State Nursing Home Case-Mix and Quality (NHCMQ) demonstration was used for Medicare classification. In the Medicare pilot, a nurse reviewed weekly new admissions on site to verify the classification of the residents into the RUG-T18 groups. The interrater reliability between the project nurse and the facility nurses was excellent. A paper, "Texas Medicare Case-Mix Pilot Study," which describes the pilot test and the data reliability processes, was presented at the National Case-Mix Conference in Maine in 1993. The lessons learned from this pilot will be used in implementating the NHCMQ demonstration. The final report of this project has been received and is currently under review.

94-084 Use of Long-Term Care Services by Mentally Ill Persons

Project No.:	17-C-90341/3
Period:	September 1994–September 1996
Funding:	$391,331
Award:	Cooperative Agreement
Principal Investigator:	Dennis Shea, Ph.D.
Awardee:	Center for Health Policy Research Institute for Policy Research and Evaluation Pennsylvania State University Office of Sponsored Programs 110 Technology Center University Park, PA 16802
HCFA Project Officer:	Ellen O'Brien Division of Aging and Disability

Description: There has been a steady increase in the utilization of long-term care services, particularly nursing homes, by mentally ill persons as a result of the decline in State and county mental hospitals in the 1960s and 1970s. The emptying of the mental hospitals resulted in increased demand for the treatment of mentally ill persons in other inpatient settings. Although preadmission screening and resident review is intended to prevent mentally ill persons with no functional impairment from being treated in nursing facilities, the vast majority of persons with mental illness admitted to nursing facilities have physical functional impairments as well.

This project examines the determinants of long-term care service use by the mentally ill population. Information on persons, providers, and system characteristics, together with a more complete description of current use patterns, will help to identify the potential impacts of policy changes on use of services and total program costs. Data from the National Medical Expenditures Survey (NMES) Institutional Component, the Medicare Current Beneficiary Survey (MCBS), and the National Nursing Home Survey are being used to model long-term care use by this population.

Status: Descriptive data from NMES have been used to examine differences in nursing home expenditures by persons with and without reported or diagnosed mental illness. These results indicate the following:

- Mental illnesses explain variations in service use, with the effects depending on how mental illness is defined and whether a resident or admission cohort is examined
- Newly admitted nursing home residents with a mental illness have higher charges due to lengths of stay that are 35 percent longer than non-mentally ill admissions.
- Charges vary little between persons with or without a mental illness.

These results suggest that if future reimbursement policy in long-term care settings is moving toward capitation, as has occurred in other settings, rates should take into account the longer stay associated with persons with mental illness.

Results from the initial descriptive analyses of the MCBS indicate that 5 years after the passage of the 1987 Nursing Home Reform Act, which mandated treatment of mental illnesses, there is a persistent level of untreated mental illness in nursing homes. Only 29 percent of nursing home residents with a mental illness were treated by mental health specialists during the year. Regarding the use of other long-term care services, a significant relation has also been detected between diagnosis of a mental illness and home health use.

92-040 Validation of Nursing Home Quality Indicators

Project No.:	18-C-90090/9
Period:	July 1992–July 1996
Funding:	$992,231
Award:	Cooperative Agreement
Principal Investigator:	Tamra J. Lair, Ph.D.
Awardee:	SysteMetrics/McGraw-Hill 104 West Anapamu Street Santa Barbara, CA 93101
HCFA Project Officer:	Kay Lewandowski Division of Aging and Disability

Description: This project is a continuation of a cooperative agreement to investigate the usefulness of claims data from Medicaid and Medicare administration record systems as sources of nursing home quality-of-care measures. The previous study involved retrospective analysis of 1987 Medicaid and Medicare claims data and facility deficiency data from two States. The goal of this project is to further the development of an automated quality assurance system using Medicare and Medicaid claims data to provide continuous monitoring of the quality of care rendered to Medicaid recipients in long-term care facilities. The objective is to validate the resident-level claims-based quality of care indicators (QCI) by recomputation of the claims-based indicators for two States using data for 1990; physician and nurse examination of medical records for a sample of residents in a sample of nursing homes for these two States; and establishment of the relationship of the QCIs to cited deficiencies and adverse outcomes.

Status: This project has completed collection of medical record data from the two States, and the review of the data by nurse and physician evaluators has begun. The period of the grant has been extended to July 1996.

Intramural

IM-034 Determinants of Home Health Use

Funding: Intramural
HCFA Project Director: Elizabeth Mauser, Ph.D.
Division of Aging and Disability

Description: Modifications in the eligibility requirements for Medicare home health services, implementation of the Medicare prospective payment system in hospitals, and beneficiary preferences to remain in the community have resulted in significant increases in Medicare home health care expenditures. Although Medicare home health expenditures continue to rise, relatively little is known about home health users and the market characteristics that affect home health use. Consequently, the Health Care Financing Administration has implemented several intramural research studies to support future efforts of payment reform in the area of post-acute care. Using the Medicare Current Beneficiary Survey (MCBS), this study is exploring the following issues:

- Whether home health users can be classified into distinct subgroups to understand the special care needs of home health users, determine how specific policies affect different groups of users, and develop case-mix adjustments for payment reform.
- How home health use has changed over time, using the 1991, 1992, and 1993 MCBS.
- The effect of supply factors on home health use by linking the MCBS with the area resource file.
- The extent of substitution among different post-acute care settings, such as skilled nursing, home health, and rehabilitation facilities.

Status: Using the 1992 MCBS, the characteristics of beneficiaries using Medicare home health were examined and multivariate models were developed to determine the factors that affect use and expenditures. Based on this work, "A Profile of Home Health Users in 1994," by Mauser, E., and Miller, N.A., appeared in the Fall issue of the *Health Care Financing Review*, 16(1):17–33, 1994. An analysis has been completed regarding the effect of organizational form on home health use. Based on this work, an article has been prepared to be presented at the American Public Health Association Meetings. (This work suggests that for-profit home health agencies provide close to 21 visits more per year to home health users).

IM-046 Study of Access to Durable Medical Equipment by Non-Aged Disabled Medicare Beneficiaries

Funding: Intramural
HCFA Project Director: William D. Clark
Division of Aging and Disability

Description: This project is examining access to durable medical equipment (DME), especially wheelchairs, by non-aged disabled Medicare beneficiaries to determine whether changes in access have resulted from DME payment changes in the Medicare program. The study will use Medicare data from 1991 through 1995 to assess changes in assignment rates, payment denials, and supplier characteristics and other variables.

Status: A project design and data request are being prepared for review. Initial discussions with industry and advocacy group representatives have been held.

Consumer Information

Extramural

95-057 Beneficiary Information, Education and Marketing Strategy

Project No.:	500-95-0063
Period:	September 1995–September 1996
Funding:	$ 515,000
Award:	Small Business Contract
Principal Investigator:	Lisa Adato
Awardee:	Benova 1220 SW. Morrison, Suite 700 Portland, OR 97205
HCFA Project Officer:	Leslie M. Greenwald, Ph.D. Division of Delivery Systems and Financing

Description: Through this project, the Health Care Financing Administration intends to: (1) develop a marketing/public relations strategy to reach all beneficiaries in the competitive bidding demonstration market area and inform beneficiaries of the enrollment process and new plan choices; (2) develop a strategy for beneficiary education; and understanding about increased health plan options under Medicare; and (3) develop strategies and materials that will enable beneficiaries to choose effectively between new and different types of insurance plans in an open enrollment process.

Status: This contract is in the early development stage.

95-025 Comparison of Income Information on 1990 Census with Information Collected by the Current Beneficiary Survey

Project No.:	HCFA-95-0265
Period:	March 1995–June 1995
Funding:	$ 23,388
Award:	Purchase Order
Principal Investigator:	A. Marshall McBean, M.D.
Awardee:	University of Minnesota Delaware Street, SE. Minneapolis, MN 55455
HCFA Project Officer:	Leslye Fitterman, Ph.D. Division of Health Information and Outcomes

Description: This study compared self-reported income as collected in the Medicare Current Beneficiary Survey (MCBS) with income in the Bureau of the Census Survey. The purpose was to determine the usefulness of socioeconomic information from the Bureau of the Census to augment Medicare claims data to examine racial differences in access, utilization, and outcomes of care. A data file was constructed from the Bureau of the Census data that assigned age- and race-specific median household income to each Zip code. The age- and race-specific data were calculated using the distribution of age and race within the population 65 years of age and older in each Zip. The MCBS data file contained income, age, race, and address. A computer program matched address and Zip code from the MCBS file to census tract and census-block group. The comparison between the two data sources was performed at three levels: Zip code, census tract, and census-block group.

Status: The study findings suggest that Zip code level median income derived from Bureau of the Census data for elderly persons was higher by age and racial subgroups than the MCBS survey information.

95-075 Data User's Conference for Historically Black Colleges and Universities

Project No.:	HCFA-95-0719
Period:	September 1995–January 1996
Funding:	$ 25,000
Award:	Contract
Principal Investigator:	Dean Thomas Blocker
Awardee:	Morehouse College 830 Westview Drive, SW. Atlanta, GA 30314
HCFA Project Officer:	Richard Bragg Division of Aging and Disability

Description: The Health Care Financing Administration provided funds to Morehouse College to facilitate a data user's conference for Historically Black Colleges and Universities (HBCUs). The purpose of the data conference is to enhance the capacity of HBCUs to participate in the broad array of HCFA program activities. Specifically, HCFA hopes to increase HBCUs' capability to conduct health services research using HCFA data. As a result of participating in this conference, HCFA anticipates that HBCUs will become involved in the design, implementation, and operation of research projects that address health care issues such as reform, financing, delivery, access, and quality.

This conference is an initial attempt to develop ties between researchers at these universities and HCFA staff. It is planned to foster a research network among the HBCUs regarding health care issues.

This is the first data conference sponsored by HCFA as a means of supporting research efforts at HBCUs. Traditionally, HBCUs have had very little involvement with HCFA, as well as with most other Federal agencies. The Data User's Conference will provide opportunities for HBCUs and their researchers (faculty members) to work with HCFA staff and to develop a greater understanding of the research priorities and opportunities that exist. A greater awareness and involvement of HBCUs in HCFA programs would serve four important purposes:

- To become knowledgeable about these African-American institutions.
- To understand HBCUs' abilities to implement efforts to address the health and social problems of concern to HHS.
- To increase the pool of researchers available in carrying out the research, demonstration, and evaluation activities of HCFA.
- To fulfill the spirit of Executive Order 12876, in which the President has ordered Federal agencies to support the development and increase the utilization of the resources that exist at HBCUs.

Status: The Data User's Conference was held on October 18–19, 1995. The following task is being completed: assisting and facilitating conference participants in developing a regional research network to address health care issues in the African-American community.

94-099 Effects of Information and Consumer Knowledge on Choice of Health Plans

Project No.:	17-P-90348/5
Period:	September 1994–March 1996
Funding:	$ 193,096
Award:	Grant
Principal Investigator:	Francois Sainfort, Ph.D.
Awardee:	Center for Health Systems Research and Analysis University of Wisconsin 750 University Avenue Madison, WI 53706
HCFA Project Officer:	Judith A. Sangl, Sc.D. Division of Health Information and Outcomes

Description: The primary purpose of this research involves studying how consumers make decisions about health care coverage and what role their knowledge about health plans plays in this decision process. A computerized data collection system will be used to elicit consumer preference structures and to track the information search process, as well as record their actual plan choices under scenarios with differing amounts and types of information presented about each plan option. A pilot study based on a series of in-depth, face-to-face interviews with a small group of consumers will be conducted to test and refine the initial conceptual model and to design the data collection system. A sample of 200 persons will be chosen from the study population of the employees of the State of Wisconsin who live within 1-hour's driving time of Madison, Wisconsin.

Status: The following project activities have been conducted:

- The computerized data collection system was developed and tested with a convenience sample.
- The final sample was drawn from the database of state employees with the assistance of the Wisconsin Department of Employee Trust Funds.
- Testing of the State employees during their open enrollment season for health insurance has begun.

95-003 Evaluation of the Effectiveness of the Operation Restore Trust Demonstrations

Project No.:	500-92-0014DO06
Period:	September 1995–September 1997
Funding:	$ 738,062
Award:	Contract
Principal Investigator:	Robert Coulam, Ph.D., J.D.
Awardee:	Abt Associates, Inc. (See page 203)
HCFA Project Officer:	Edward Norwood Division of Demonstrations Support

Description: The purpose of this contract is to conduct an evaluation of the demonstration project, Operation Restore Trust. The Office of Inspector General (OIG), Administration on Aging (AOA), and Health Care Financing Administration have jointly developed a model to demonstrate improved methods for investigation and prosecution of fraud and abuse in the provision of care or services under the health programs established by the Social Security Act, Public Law 90-248, section 402 (a)(1)(J). The effort will consolidate the talents and expertise of the staff of the partner and other Federal agencies in five designated States and will focus on home health agencies, hospices, nursing facilities, and durable medical providers.

The evaluation will determine whether the more concentrated effort rendered through the partnership model is effective and what impact the partnership model has on industry fraudulent behavior. The demonstration is scheduled to be conducted for a 2-year period ending February 27, 1997.

Status: This project is in the developmental stage.

95-001 Evaluation of the Impact of Health Plan Report Cards on Consumer Knowledge, Attitudes, and Choice in a Managed Competition Setting

Project No.:	18-P-90601/5
Period:	September 1995–September 1996
Funding:	$ 334,542
Award:	Grant
Principal Investigator:	David J. Knutson
Awardee:	Park Nicollet Medical Foundation 3800 Park Nicollet Boulevard St. Louis Park, MN 55416
HCFA Project Officer:	Sherry A. Terrell, Ph.D. Division of Delivery Systems and Financing

Description: The purpose of this study is to determine whether the dissemination of report card information about health care plans to consumers who choose health plans within a managed care competition framework will influence their knowledge of health plan characteristics, attitudes toward health plans, or choice of a health plan. The study population is employees of the State of Minnesota Group Insurance Program, in which employees select health plans during an annual fall open enrollment period. Some members of the program will receive report cards before they make their 1995 enrollment decisions, and a control group will not. Both groups will be surveyed before and after they make their health plan selections. Results will assist policy makers to determine how to shape health plan report cards to best assist consumer decision making.

Status: This project is a recent award but is on a fast track, given the subject matter interest. Telephone interviews for the preenrollment survey have been completed. The postenrollment interviewing will be completed by December 1995. Data analysis and report preparation will occur between March and August 1996. A final report is expected by September 1996.

94-098 Information Needs for Consumer Choice

Project No.:	500-94-0047
Period:	September 1994–July 1996
Funding:	$ 714,719
Award:	Contract
Principal Investigator:	Barri Barrus, Ph.D.
Awardee:	Research Triangle Institute P.O. Box 12194 Research Triangle Park, NC 27709-2194
HCFA Project Officer:	Judith A. Sangl, Sc.D Division of Health Information and Outcomes

Description: This contract will examine the types of information consumers would find most useful in selecting health insurance plans, providers, and practitioners, and in making the chosen health care plan/system work best for them. The study will determine how to present this type of information in a user-friendly way and will develop and test these consumer information approaches in given markets. The awardee will address consumer information issues and needs in both the current health care system and in proposals for health care system reform, especially as they relate to three broad consumer groups: Medicare beneficiaries, Medicaid beneficiaries, and the remaining U.S. Population under 65 years of age. Contract tasks include conducting up to 24 focus groups, conducting 9 case studies of innovative consumer information projects, and developing and testing information materials in 2 different media for 6 subgroups of the Medicare and Medicaid populations.

Status: The focus groups and case studies have been completed. The results of the focus groups indicate that information needs varied across insurance groups. In general, Medicare beneficiaries were concerned with their access to current providers and the specialists of their choice, providers' communication skills, technical quality of care, and specific benefits relevant to their circumstances. Beneficiaries were aware of cost, but it was rarely a primary decision factor. Many of those approaching Medicare eligibility were uninformed about the basic structure of Medicare and supplemental coverage. Medicaid eligibles were most interested in access to after-hours care, provider choice, waiting time, and providers' communication and interpersonal skills.

Participants assessed the usefulness of three kinds of information for plan choice: consumer ratings, quality-of-care measures, and cost comparisons. Most responded favorably to samples of consumer ratings of plan

performance. Differences in familiarity with surveys was apparent, with some participants requiring explanation of basic concepts of an independent survey, while others raised fairly sophisticated concerns regarding survey design and administration. Participant reactions to quality-of-care measures were more cautious. Many saw preventive care utilization as indicative of consumers' responsible actions rather than plan quality. Media preferences varied by insurance groups. Medicare beneficiaries consistently preferred a combination of individual or group presentations with printed reference material. Medicaid eligibles wanted group counseling sessions, similar to those they currently receive, but with the addition of detailed information on available plans. All participants said they preferred to receive information from unbiased, consumer-oriented sources.

The case study component of this project served an important purpose, which was to learn about and from organizations across the country that were developing information to assist consumers in choosing a health plan and using the health care system. A total of 24 in-person interviews were conducted with a variety of organizations active in the consumer information field. Through the case studies, we identified a list of candidate performance measures, or quality indicators, for inclusion in our prototype materials that will be developed and tested on consumers. In addition, a list of potential formats/modes of communications was generated.

Overall, traditional health plan information, such as premium amounts and benefit coverage, was the most common type of data included in the consumer materials reviewed. However, approximately one-half of the organizations also used selected survey-based satisfaction measures, as well as statistical performance measures based on administrative data. The printed report card was the most common format encountered; most report cards include a combination of text and graphics. Cost, space limitations, and level of expertise greatly influenced the choice of communication modes. On the whole, the materials developed by case study organizations have not undergone rigorous evaluations.

90-015 **Pilot Test of the Medicare Beneficiary Health Status Registry**

Project No.: 500-90-0053
Period: April 1990–December 1994
September 1990–September 1992 (Design Phase)
September 1992–December 1994 (Field Test Phase)
Funding:$ 1.8 million
$ 396,940 (Design Phase)
$ 1.4 million (Field Test Phase)
Award: Contract
Principal Investigator: Charles Turner, Ph.D.
Awardee: Research Triangle Institute
P.O. Box 12194
Research Triangle Park, NC 27709-2194
HCFA Project Officer: Thomas W. Reilly, Ph.D.
Division of Health Information and Outcomes

Description: The Medicare Beneficiary Health Status Registry (Registry) is envisioned to be a longitudinal database containing information on Medicare beneficiaries from the time of enrollment into Medicare until death. The Registry will be composed of health status information obtained by periodic surveys linked at the person level to the administrative files maintained by the Health Care Financing Administration. Survey data will be gathered about five areas related to health status: (1) risk factors, (2) functional status, (3) sociodemographic variables, (4) medical history, and (5) quality of life. The primary goals of the Registry will be to monitor the health status of Medicare beneficiaries and to provide data to evaluate the relationship between the use and costs of health care services provided by Medicare and the health of beneficiaries. The Registry differs from other existing data sources because it will collect longitudinal data on the health status for a very large sample of Medicare beneficiaries. This contract conducted a pilot study of the methodology proposed for use in the Registry.

Status: We have recently completed the pilot test to determine whether it is feasible to collect data on health status from Medicare beneficiaries by means of a mailed survey, with telephone followup of nonrespondents, as is planned for the Registry. The pilot included a national probability sample of over 1,200 new Medicare beneficiaries and over 1,200 beneficiaries 76-80 years of age. In both the new and older enrolled groups, the response rate was approximately 80 percent, which was considered good, especially given the relatively low cost of the data collection method. In addition, item completion rates for returned questionnaires were in the 90-95-percent range for most questions. Such results indicate that it is feasible to collect data on the health status of Medicare beneficiaries by means of the methodology proposed for the Registry. Papers detailing results from the pilot study are under preparation.

Intramural

IM-031 **Breast Cancer Treatment Initiative**

Funding: Intramural
HCFA Project Director: Joan L. Warren, Ph.D.
Division of Health Information and Outcomes

Description: As part of the production of consumer information, the Health Care Financing Administration plans to use its administrative claims data in tandem with information from the National Cancer Institute to produce information aimed to help Medicare beneficiaries make more informed choices about available therapies for breast cancer. These data will be available to women with breast cancer and health care professionals. Data will be produced regarding the frequency of breast conserving surgery for early stage breast cancer and the frequency of use of radiation therapy following breast conserving surgery. Data will be for all women with breast cancer as well as for specific age and race groups.

Status: An updated linkage of data from the National Cancer Institute with Medicare data should be completed by December 1995. Analysis of the data can begin at that time.

IM-048 Development Activities of the HBCU Network

Funding:	Intramural
HCFA Project Director:	Richard Bragg Division of Aging and Disability

Description: Utilizing a networking system, the Historically Black Colleges and Universities (HBCUs) are able to do the following:

- Channel health related research information.
- Stimulate the need for culturally sensitive research.
- Provide technical assistance for addressing the unique health needs of African Americans and other minorities.
- Facilitate the cohesion of a strong core of researchers with experience in and sensitivity to health-related research on the black community.

The purposes of the HBCU Network are as follows:

- Develop and foster research on the health needs of African Americans and to help reduce differentials in health status between blacks and whites.
- Set priorities on health research needs in African-American populations.
- Encourage collaborative research by bringing together institutions and individuals concerned with increasing health-related research in African-American populations in order to create a regional, cultural mass of relevant expertise.
- Develop a coordinated program to increase the number of black health researchers.

Status: The project is under development.

IM-030 Influenza Immunization Initiative

Funding:	Intramural
HCFA Project Director:	Marsha G. Davenport, M.D., M.P.H. Division of Health Information and Outcomes

Description: As part of the Consumer Information Strategy, the Health Care Financing Administration is seeking to increase the number of influenza immunizations among Medicare beneficiaries to reach the year 2000 goal of a 60-percent influenza immunization rate for all persons 65 years of age or older. The influenza initiative involves a public awareness campaign, outreach activities among several peer review organizations, and the production and dissemination of Medicare influenza immunization rates. Influenza immunization rates were developed from all claims paid by the Medicare program for Part B Medicare beneficiaries 65 years of age or older who received immunizations in the fee-for-service sector between September 1 and December 31, 1994. Rates were prepared for the Nation, States, and counties, as well as by gender, age, and race. It is hoped that the dissemination of the data on Medicare paid immunizations will help increase awareness of the Medicare-influenza immunization benefit and will assist in achieving a 60-percent immunization rate for the elderly Medicare population.

Status: The production of the data book entitled *1994 Influenza Immunizations Paid for by Medicare* has been completed. Dissemination of this data book is currently in progress.

IM-047 Inventory of Projects with Special Focus on African Americans and Other Minorities

Funding:	Intramural
HCFA Project Director:	Richard Bragg Division of Aging and Disability

Description: The objectives of this project are as follows:

- To inventory Office of Research and Demonstrations research, evaluation, and demonstration projects to determine their effects on African Americans as related to health status, access to service, utilization, and out-of-pocket expenditures.
- To determine the participation of African-American populations in extramural and intramural research efforts related to the health care delivery service.
- To promote the Health Care Financing Administration's research that will be aimed at developing a better understanding of health care services issues pertaining to African Americans.
- To prepare a compendium that emphasizes aforementioned activities.

Status: This project is under development.

IM-033 **Prostate Disease Information Initiative**

Funding: Intramural
HCFA Project Director: Maria A. Friedman
Dissemination Staff

Description: As part of a new consumer information strategy, the Health Care Financing Administration is seeking to help beneficiaries make more informed choices about treatment options for prostate disease. This includes educating beneficiaries and providers about the full range of therapeutic options available for treatment of prostate-related problems. These are common in elderly men, and their treatment costs Medicare millions of dollars annually. Some prostate conditions are cancerous. In fact, prostate cancer is the most common form of cancer among American men. Surgical treatment for prostate cancer is on the rise. Yet, this course is controversial and its effectiveness has been questioned in relation to nonsurgical options. Other prostate conditions are benign. Half of all men 60 years of age or over have swelling of the prostate called benign prostatic hyperplasia (BPH). By 80 years of age, one man in four will require treatment for it. However, BPH and some of its treatments have major side effects that significantly affect beneficiaries' quality of life. For example, men with BPH often experience frequent urination or, conversely, difficulty in postponing urination. Surgical treatment of BPH can cause urinary incontinence and impotence. As a result, patients need to have information available to make an informed treatment choice. Providers need to be educated about treatment options and trained to work with consumers to help them better understand available options.

Status: Preliminary work is under way to review the statistical information available from the Medicare program, other Federal agencies, and private-sector sources and to review consumer-related information also available from the Medicare program, other Federal agencies, and private-sector sources. Use and testing of educational strategies, such as shared decisionmaking, are being explored.

Extramural

90-062 Medicaid Analysis Project for States

Project No.:	500-90-0045
Period:	September 1990–March 1996
Funding:	$ 5,529,431
Award:	Contract
Principal Investigator:	Suzanne Dodds
Awardee:	SysteMetrics, Inc. Santa Barbara Corporate Center 5425 Hollister Avenue, Suite 140 Santa Barbara, CA 93111
HCFA Project Officer:	Debbie Lewis Bureau of Data Management and Strategy

Description: This contract expands the collection of person-level data from the Medicaid Management Information Systems (MMIS) maintained by the States. Data are being collected from the States that have participated in the Medicaid Tape-to-Tape project. Major activities are as follows:

- Assisting in the production and verification of State Medicaid Research Files (SMRF) from files.
- Providing a consistent complementary link between the Medicaid Tape-to-Tape project activities and the development of SMRFs.
- Obtaining person-level data on Medicaid enrollment, use, payments, and providers from the State MMIS.
- Developing uniform data file structures to facilitate the comparison of Medicaid program statistics among these States.
- Producing streamlined research data bases to support analysis of policy and program management alternatives for Medicaid.

Status: The awardee is working with the Health Care Financing Administration in a major effort to construct SMRFs for eligibility and claims files.

92-056 Medicaid Program Research to Study Medicaid Policy Alternatives for the State of New York

Project No.:	500-92-0059
Period:	September 1992–March 1996
Funding:	$ 194,090
Award:	Contract
Principal Investigator:	Thomas Fanning, Ph.D.
Awardee:	New York State Department of Social Services 40 North Pearl Street Albany, NY 12243-0001
HCFA Project Officer:	Penelope L. Pine Division of Health Information and Outcomes

Description: The purposes of this contract are to provide the Health Care Financing Administration with greater capability to conduct Medicaid program research and to study Medicaid policy alternatives of the State of New York. Primary goals are the following:

- Obtain person-level Medicaid Management Information Systems data from the State.
- Produce research data sets for analysis of Medicaid costs and service utilization.
- Conduct policy-oriented research studies derived from knowledge of the data, program characteristics, and policy issues that exist in the New York Department of Social Services.
- Provide support to HCFA staff who will conduct policy-related studies using New York Medicaid research data sets.

Status: New York Medicaid enrollment and claims files for Federal fiscal years 1990, 1991, and 1992 have been received. The studies using the New York data are Physician Participation in the Medicaid Program, Preferred Physician and Children Program, Designated Inpatient Hospital Centers for Persons with Acquired Immune Deficiency, and Substance- Abusing Pregnant Women.

93-064 Medicare Beneficiaries Receiving Chronic Renal Dialysis Not Identified as Having End Stage Renal Disease

Project No.:	HCFA-93-0979
Period:	August 1993–May 1994
Funding:	$ 24,813
Award:	Contract
Principal Investigator:	Dennis Cotter
Awardee:	The Medical Technology and Practice Patterns Institute 2121 Wisconsin Avenue, NW. Suite 230 Washington, D.C. 20007

HCFA Project Officer:	Joel W. Greer, Ph.D. Division of Health Information and Outcomes
Mandate:	Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509)

Description: The final analyses have been completed and the final report is being prepared. The Medical Technology and Practice Patterns Institute (MTPPI) has characterized Medicare beneficiaries who submit bills indicating that they receive chronic renal dialysis, but who are not identified as having end-stage renal disease (ESRD). MTPPI will estimate the impact of these persons on ESRD program enrollment, incidence, demographic characteristics, and costs.

Status: MTPPI has identified persons receiving chronic renal dialysis who are not included in the Prepaid Medicaid Management Information System (PMMIS) and has submitted a request for the data necessary to estimate patient counts and costs.

94-005 **Patterns of Utilization and Expenditures for Prescription Drugs in Selected State Medicaid Programs**

Project No.:	500-92-0020DO08
Period:	January 1994–July 1995
Funding:	$ 236,705
Award:	Delivery Order in Master Contract
Principal Investigator:	Rezaul Khandker, Ph.D.
Awardee:	Health Economics Research, Inc. (See page 206)
HCFA Project Officer:	Herbert A. Silverman, Ph.D. Division of Payment Systems

Description: This project will analyze Medicaid data from selected States to describe patterns of prescription drug use and expenditures. The focus will be on the differential use of specific classes of drugs by classes of beneficiaries defined by demographic characteristics and program eligibility status. The impact of State administrative limits on prescription size and frequency of refills will be examined. At this time, the eight States included in the study are Alabama, California, Delaware, Georgia, Kentucky, Missouri, New Jersey, and Wyoming.

Status: Statistical tables have been prepared for the eight States, and they are being analyzed. In addition, cross-cutting tables including data from all eight States are being developed. The final report will contain chapters on eligibility and enrollment, use and spending, and an analysis of utilization and spending by therapeutic category of the drugs. The final report is expected by the end of 1995.

95-059 **Program of All-Inclusive Care for the Elderly Data Management**

Project No.:	500-95-0035
Period:	September 1995–August 1998
Funding:	$ 590,630
Award:	Contract
Principal Investigator:	Marleen L. Clark, Ph.D.
Awardee:	On Lok, Inc. 1333 Bush Street San Francisco, CA 94109
HCFA Project Officer:	Kay Lewandowski Division of Aging and Disability

Description: The purpose of this contract is to provide data management for the Program of All-Inclusive Care for the Elderly (PACE) demonstration period to ensure that a valid, reliable data set is maintained for monitoring project operations and for use by the Health Care Financing Administration's independent evaluator. This is a continuation of the previous contract with On Lok, Inc. to provide this service. DataPACE maintains a data set on PACE enrollees and manages data collection procedures at the PACE sites. In the course of this second contract, service utilization data are scheduled to be used by the PACE demonstration program's independent evaluator.

Status: The DataPACE software and data management routines have been implemented at all sites and continue to be used to monitor data quality and provide feedback to the sites.

Intramural

IM-021 **Database Development**

Funding:	Intramural
HCFA Project Directors:	Sam McNeill, Wilson Kirby, and Dan Babish Division of Data Systems and Resources

Description: The daily operations of the Medicare and Medicaid programs involve the processing, adjudication, and payment of claims for health care services. As a result, extensive records are maintained on program participants, services, and payments. By linking, tabulating, sampling, and summarizing records from the administrative databases, extensive statistical files are produced. Data development entails the further development, aggregation, and linkage of these data to support research activities. This includes the development of these types of databases:

- Benefit-specific, person-based.
- Beneficiary cost-sharing.
- Procedure-specific.
- Morbidity-specific.

- Benefit-specific database linked with provider databases.
- Enrollment database linked with person-summary databases.
- Provider of services.
- SAS and SMRF research databases.

The availability of person-specific and procedure-specific data make these databases useful for epidemiological research initiatives and a myriad of other special studies.

Status: This is an ongoing, intramural research project. Most of the databases described are maintained on a calendar year basis. Databases containing calendar year 1994 data are available and those containing calendar year 1995 data should be available by Summer 1996.

IM-022 **Data Support Activities**

Funding:	Intramural
HCFA Project Director:	Charles R. Helbing Division of Data Systems and Resources

Description: This Data Support Activities project provides data processing, graphics, desktop publishing, and statistical support services to assist analysts and researchers in developing and disseminating a wide variety of Office of Research and Demonstrations projects, congressional mandates, health care policies and legislative initiatives, and data dissemination activities. Some activities this project is involved in are Reports to Congress, *Health Care Financing Review* articles, presentations and seminars, special studies, internal reports, and press releases.

Status: This intramural project produces and disseminates current and relevant Medicare and Medicaid data on an ongoing basis. The output is maintained on computer mass storage and data diskettes. The statistical data and related information are available upon request.

IM-001 **Medicare and Medicaid Statistical Supplement: *Health Care Financing Review***

Funding:	Intramural
HCFA Project Director:	Charles R. Helbing Division of Data Systems and Resources

Description: The Annual Supplement of the *Health Care Financing Review* presents comprehensive data on the experiences of the Medicare and Medicaid programs. Each issue will contain the following:

- Extensive graphic presentations of longitudinal and cross-sectional data describing the demographic characteristics of program beneficiaries, patterns of service utilization, and program expenditures for the Medicare and Medicaid programs.
- Description of the eligibility criteria, benefit structures, and payment methods of the Medicare and Medicaid programs.
- Detailed longitudinal and cross-sectional tables describing the number and characteristics of Medicare and Medicaid beneficiaries, the use of Medicare and Medicaid benefits, and the amounts and distributions of program payments by State, demographic characteristics, and service type.

Status: The 1995 Annual Supplement has been published (September 1995). The 1996 Annual Supplement is expected to be published in Spring 1996. This issue will contain Medicaid data for fiscal year 1994 and Medicare data for calendar year 1994. The Supplement may be obtained by subscribing to the *Health Care Financing Review*. Each subscription costs $19.00 per year, domestic; $23.75, foreign. Single issues of the Supplement cost $11.00, domestic; $13.75, foreign. Single copies and subscriptions may be obtained from the Superintendent of Documents, Post Office Box 371954, Pittsburgh, Pennsylvania 15250-7954.

IM-049 **Medicare Payments from Diagnosis to Death for Elderly Cancer Patients**

Funding:	Intramural
HCFA Project Director:	Gerald F. Riley, James D. Lubitz Division of Health Information and Outcomes

Description: Medicare payments subsequent to diagnosis of cancer for elderly enrollees with five common cancers were estimated using tumor registry data from the Surveillance, Epidemiology, and End Results program linked to Medicare claims from 1984 to 1990. The time between diagnosis and death was divided into four phases corresponding to the clinical course of solid tumors, average payments for each phase were estimated (including payments for services not related to cancer), then phase-specific payment data were aggregated.

Average payments by phase varied among cancer sites, especially in the initial care phase, where payments were highest for lung and colorectal cancers ($17,500 in 1990 dollars) and lowest for female breast cancer ($8,913). Total Medicare payments from diagnosis to death were highest for persons with bladder cancer ($57,629) and lowest for those with lung cancer ($29,184). Low payments for persons with lung cancer corresponded to brief survival times. Persons diagnosed at earlier stages incurred higher total payments between diagnosis and death than those diagnosed at later stages, reflecting their longer survival. This implies that early detection may increase total Medicare expenditures by extending beneficiaries' lives. However, Medicare payments per year of survival were lower for earlier stages.

Status: Results were published under the following citation: Riley, G.F., Potosky, A.L., Lubitz, J.D., Kessler, L.G.: "Medicare Payments from Diagnosis to Death for Elderly Cancer Patients by Stage of Diagnosis." *Medical Care*, 33:828-841, 1995. Followup work has begun to estimate Medicare payments following a diagnosis of cancer that are directly attributable to cancer care. Followup work is being conducted jointly by Health Care Financing Administration and the National Cancer Institute.

IM-020 **Program Information Inquiries**

Funding:	Intramural
HCFA Project Director:	Roger E. Keene Division of Data Systems and Resources

Description: The primary objective of the Program Information Inquiries project is to provide the Health Care Financing Administration, other Federal Government agencies, and the entire health care community with current and historical Medicare and Medicaid data in response to health care information requests. Medicare and Medicaid data and related information are available on enrollment, service utilization, program payments, providers of services, morbidity, procedures, diagnosis-related groups, and beneficiary cost-sharing.

Status: This ongoing intramural project derives data from an extensive inventory of HCFA statistical and analytical files, which are a by-product of the daily administrative operations of the Medicare and Medicaid programs involving the processing, adjudication, and payment of claims for covered health care services. Program-wide data generally are available within 9 months after the close of the year and are available upon request.

Master Contracts and Research Centers

Extramural

92-083 **Medicaid Demonstration and Evaluation Support Projects: Master Contract: Abt Associates, Inc.** (Formerly, Medicaid Demonstration and Evaluation Support Projects: Master Contracts)

Project No.:	500-92-0034
Period:	September 1992–September 1995
Award:	Contract
Principal Investigator:	David Kidder
Awardee:	Abt Associates, Inc. 55 Wheeler Street Cambridge, MA 02138
HCFA Project Officer:	Bonnie M. Edington Division of Health Information and Outcomes

Description: This master contract provides for the design, development, conduct, and evaluation of Medicaid demonstration and evaluation support projects. The intent of these demonstration projects is to obtain information in a timely manner for program and policy consideration.

Status: This master contract was awarded in September 1992. This awardee is able to compete for individual delivery orders (DO) for 36 months. The first DO (awarded concurrently with the base contract) is for general management, which includes submitting monthly reports, meeting with the Federal Government on request, and responding to requests for issue papers. The overall 36-month funding amount of the first DO, 500-92-0034DO01, Management Delivery Order, is $32,845.

This awardee has not been awarded any additional delivery orders.

92-085 **Medicaid Demonstration and Evaluation Support Projects: Master Contract: Lewin/VHI, Inc.** (Formerly, Medicaid Demonstration and Evaluation Support Projects: Master Contracts)

Project No.:	500-92-0036
Period:	September 1992–September 1995
Award:	Contract
Principal Investigator:	Allen Dobson, Ph.D.
Awardee:	Lewin/VHI, Inc. 9300 Lee Highway, Suite 400 Fairfax, VA 22031-1207
HCFA Project Officer:	Bonnie M. Edington Division of Health Information and Outcomes

Description: This master contract provides for the design, development, conduct, and evaluation of Medicaid demonstration and evaluation support projects. The intent of these demonstration projects is to obtain information in a timely manner for program and policy consideration.

Status: This master contract was awarded in September 1992. This awardee is able to compete for individual delivery orders (DO) for 36 months. The first DO (awarded concurrently with the base contract) is for general management, which includes submitting monthly reports, meeting with the Federal Government on request, and responding to requests for issue papers. The overall 36-month funding amount of the first DO, 500-92-0036DO01, Management Delivery Order, is $26,797.

This awardee has not been awarded any additional awards.

92-086 **Medicaid Demonstration and Evaluation Support Projects: Master Contract: Mathematica Policy Research, Inc.** (Formerly, Medicaid Demonstration and Evaluation Support Projects: Master Contracts)

Project No.:	500-92-0037
Period:	September 1992–September 1995
Award:	Contract
Principal Investigator:	George E. Wright, Ph.D.
Awardee:	Mathematica Policy Research, Inc. 600 Maryland Avenue, SW., Suite 550 Washington, DC 20024-2512
HCFA Project Officer:	Bonnie M. Edington Division of Health Information and Outcomes

Description: This master contract provides for the design, development, conduct, and evaluation of Medicaid demonstration and evaluation support projects. The intent of these demonstration projects is to obtain information in a timely manner for program and policy consideration.

Status: This master contract was awarded in September 1992. This awardee is able to compete for individual delivery orders (DO) for 36 months. The first DO (awarded concurrently with the base contract) is for general management, which includes submitting monthly reports, meeting with the Federal Government on request, and responding to requests for issue papers. The overall 36-month funding amount of the first DO, 500-92-0037DO01, Management Delivery Order, is $27,569.

The individual DO projects awarded under the master contract are described in detail in the following sections of this *Status Report*.

Access and Quality of Care:
- Federally Qualified Health Centers, 500-92-0037DO01.

92-082 **Medicaid Demonstration and Evaluation Support Projects: Master Contract: Research Triangle Institute** (Formerly, Medicaid Demonstration and Evaluation Support Projects: Master Contracts)

Project No.:	500-92-0033
Period:	September 1992–September 1997
Award:	Contract
Principal Investigator:	James Lubalin, Ph.D.
Awardee:	Research Triangle Institute P.O. Box 12194 Research Triangle Park, NC 27709-2194
HCFA Project Officer:	Bonnie M. Edington Division of Health Information and Outcomes

Description: This master contract provides for the design, development, conduct, and evaluation of Medicaid demonstration and evaluation support projects. The intent of these demonstration projects is to obtain information in a timely manner for program and policy consideration.

Status: This master contract was awarded in September 1992. This awardee is able to compete for individual delivery orders (DO) for 36 months. The first DO (awarded concurrently with the base contract) is for general management, which includes submitting monthly reports, meeting with the Federal Government on request, and responding to requests for issue papers. The overall 36-month funding amount of the first DO, 500-92-0033DO01, Management Delivery Order, is $52,099. The master contract has been given a no-cost extension through September 1997.

The individual DO projects awarded under the master contract are described in detail in the following sections of the *Status Report*.

Health Care Systems Reform and Financing:
- Study of State Health Care Reform Initiatives, 500-92-0033DO03.
- Evaluation of the Demonstration Entitled Delaware Health Care Partnership for Children, 500-92-0033.

Managed Care Systems:
- Evaluation of Medicaid-Managed Care Programs with 1915(b) Waivers, 500-92-0033DO02.

92-084 **Medicaid Demonstration and Evaluation Support Projects: Master Contract: SysteMetrics/MedStat** (Formerly, Medicaid Demonstration and Evaluation Support Projects: Master Contracts)

Project No.:	500-92-0035
Period:	September 1992–September 1995
Award:	Contract
Principal Investigator:	Marilyn Ellwood
Awardee:	SysteMetrics/MedStat 104 West Anapamu Street Santa Barbara, CA 93101
HCFA Project Officer:	Bonnie M. Edington Division of Health Information and Outcomes

Description: This master contract provides for the design, development, conduct, and evaluation of Medicaid demonstration and evaluation support projects. The intent of these demonstration projects is to obtain information in a timely manner for program and policy consideration.

Status: This master contract was awarded in September 1992. This awardee is able to compete for individual delivery orders (DO) for 36 months. The first DO (awarded concurrently with the base contract) is for general management, which includes submitting monthly reports, meeting with the Federal Government on request, and responding to requests for issue papers. The overall 36-month funding amount for the first DO, 500-92-0035DO01, Management Delivery Order, is $41,151.

The individual DO project awarded under the master contract is described in detail in the following section of this *Status Report*.

Health Care Systems Reform and Financing:
- State Health Care Reform Monitoring, 500-92-0035/DO03.

Subacute and Long-Term Care:
- Community-Supported Living Arrangements Program: Process Evaluation, 500-92-0035DO02.

92-081 **Medicare Ambulatory and Coordinated Care Demonstration Projects: Master Contract: Abt Associates, Inc.** (Formerly, Medicare Ambulatory and Coordinated Care Demonstration Projects: Master Contracts)

Project No.: 500-92-0014
Period: July 1992–July 1997
Award: Contract
Principal Investigator: David Kidder, Ph.D.
Awardee: Abt Associates, Inc.
55 Wheeler Street
Cambridge, MA 02138-1168
HCFA Project Office: Samuel L. Brown
Division of Aging and Disability

Description: This master contract provides for the design, development, conduct, and evaluation of Medicare ambulatory and coordinated care demonstration projects. The intent of these demonstration projects is to obtain information in a timely manner for program and policy consideration.

Status: This master contract was awarded in July 1992. This awardee is able to compete for individual delivery orders (DO) for 36 months. The first DO (awarded concurrently with the base contract) is for general management, which includes monthly Federal reports, meeting with the Federal Government on request, and responding to requests for issue papers. The funding amount for the first DO, 500-92-0014DO01, Management Delivery Order, is $33,137.

The individual DO projects awarded under the master contract are described in detail in the following sections of this *Status Report*.

Subacute and Long-Term Care:
- Community Nursing Organization Demonstration External Quality Assurance, 500-92-0014DO04.
- External Assessment of Quality Assurance in the Program of All-Inclusive Care for the Elderly, 500-92-0014DO02.

Health Care Systems Reform and Financing:
- Medicare Competitive Pricing Demonstration, 500-92-0014DO05.

Consumer Information
- Evaluation of the Effectiveness of the Operation Restore Trust Demonstration, 500-92-0014DO06.

94-095 **Medicare Ambulatory and Coordinated Care Demonstration Projects: Master Contract: Brandeis University**

Project No.: 500-94-0043
Period: September 1994–September 1997
Award: Contract
Principal Investigator: Stanley Wallack, Ph.D.
Awardee: Brandeis University
Heller Graduate School
Institute for Health Policy
415 South Street
P.O. Box 9110
Waltham, MA 02254-9110
HCFA Project Officer: Samuel L. Brown
Division of Aging and Disability

Description: This master contract provides for the design, development, conduct, and evaluation of Medicare ambulatory and coordinated care demonstration projects. The intent of these demonstration projects is to obtain information in a timely manner for program and policy consideration.

Status: This master contract was awarded in September 1994. This awardee is able to compete for individual delivery orders (DO) for 12 months. The first DO (awarded concurrently with the base contract) is for general management, which includes monthly reports, meeting with the Federal Government on request, and responding to requests for issue papers. The funding amount for the first Management DO, 500-94-0043DO01, is $10,530.

The individual DO project awarded under this master contract is described in detail in the following section of this *Status Report*.

Managed Care:
- Medicare End Stage Renal Disease Capitation Demonstration, 500-94-0043DO02.

92-080 **Medicare Ambulatory and Coordinated Care Demonstration Projects: Master Contract: Health Economics Research, Inc.** (Formerly, Medicare Ambulatory and Coordinated Care Demonstration Projects: Master Contracts)

Project No.: 500-92-0013
Period: July 1992–July 1997
Award: Contract
Principal Investigator: Jerry Cromwell, Ph.D.

Awardee:	Health Economics Research, Inc. 300 Fifth Avenue, 6th Floor Waltham, MA 02154
HCFA Project Officer:	Samuel L. Brown Division of Aging and Disability

Description: This master contract provides for the design, development, conduct, and evaluation of Medicare ambulatory and coordinated care demonstration projects. The intent of these demonstration projects is to obtain information in a timely manner for program and policy consideration.

Status: This master contract was awarded in July 1992. This awardee is able to compete for individual delivery orders (DO) for 36 months. The first DO (awarded concurrently with the base contract) is for general management, which includes monthly funding reports, meeting with the Federal Government on request, and responding to requests for issue papers. The funding amount for the first DO, 500-92-0013DO01, Management Delivery Order, is $53,898.

The individual DO project awarded under the master contract is described in detail in the following section of this *Status Report*.

Provider Payment:
- Medicare Participating Heart Bypass Center Demonstration Extended Evaluation, 500-92-0013DO03.
- Per Case Payment to Encourage Risk Management and Service Integration in the Inpatient Acute Care Setting, 500-92-0013DO05.

Service Delivery Systems:
- Medicare Negotiated Bundled Payment Demonstrations: Design and Solicitation, 500-92-0013DO04.

92-078 **Medicare Ambulatory and Coordinated Care Demonstration Projects: Master Contract: Mathematica Policy Research, Inc.** (Formerly, Medicare Ambulatory and Coordinated Care Demonstration Projects: Master Contracts)

Project No.:	500-92-0011
Period:	July 1992–July 1997
Award:	Contract
Principal Investigator:	Randall S. Brown, Ph.D.
Awardee:	Mathematica Policy Research, Inc. P.O. Box 2393 Princeton, NJ 08543-2393
HCFA Project Officer:	Samuel L. Brown Division of Aging and Disability

Description: This master contract provides for the design, development, conduct, and evaluation of Medicare ambulatory and coordinated care demonstration projects. The intent of these demonstration projects is to obtain information in a timely manner for program and policy consideration.

Status: This master contract was awarded in July 1992. This awardee is able to compete for individual delivery orders (DO) for 36 months. The first DO (awarded concurrently with the base contract) is for general management, which includes monthly reports, meeting with the Government on request, and responding to requests for issue papers. The funding amount for the first DO, 500-92-0011DO01, Management Delivery Order, is $34,951.

The individual DO projects awarded under the master contract are described in detail in the following sections of this *Status Report*.

Managed Care Systems:
- Evaluation of the Cost of Health Maintenance Organizations and Health Care Prepayment Plans, 500-92-0011DO03.
- Evaluation of the Medicare Case Management Demonstrations, 500-92-0011DO02.

Provider Payment:
- Medicare-Preferred Provider Organization, 500-92-0011DO05.
- Physician Capitation for Medicare Services: Feasibility Study and Demonstration Design, 500-92-0011DO04.

Managed Care Systems:
- Evaluation of Medicare Choice Demonstration, 500-92-0011DO06.

92-075 **Medicare Institutional/ Facility-Based Services Demonstration Projects: Master Contract: Center for Health Policy Research** (Formerly, Medicare Institutional/Facility-Based Services Demonstration Projects: Master Contracts)

Project No.:	500-92-0046
Period:	September 1992–September 1995
Award:	Contract
Principal Investigator:	Peter W. Shaughnessy, Ph.D.
Awardee:	Center for Health Policy Research 1355 South Colorado Boulevard, Suite 706 Denver, CO 80222
HCFA Project Officer:	Victor G. McVicker Division of Delivery Systems and Financing

Description: This master contract provides for the design, development, conduct, and evaluation of Medicare institutional/facility-based services demonstration projects. The intent of these demonstration projects is to obtain information in a timely manner for program and policy consideration.

Status: This master contract was awarded in September 1992. This awardee is able to compete for individual delivery orders (DO) for 36 months. The first DO (awarded concurrently with the base contract) is for general management, which includes submitting monthly reports, meeting with the Federal Government on request, and responding to requests for issue papers. The overall 36-month funding amount for the first DO, 500-92-0046DO01, Management Delivery Order, is $50,846. This master contract ended on September 30, 1995.

The individual DO project awarded under the master contract is described in detail in the following section of this *Status Report.*

Service Delivery Systems:
- Analysis of Expansion of Access to Care through the Use of Telemedicine and Mobile Health Services, 500-92-0046DO02.

92-076 **Medicare Institutional/ Facility-Based Services Demonstration Projects: Master Contract: Mathematica Policy Research, Inc.** (Formerly, Medicare Institutional/Facility-Based Services Demonstration Projects: Master Contracts)

Project No.:	500-92-0047
Period:	September 1992–September 1995
Award:	Contract
Principal Investigator:	Judith Wooldridge
Awardee:	Mathematica Policy Research, Inc. P.O. Box 2393 Princeton, NJ 08543-2393
HCFA Project Officer:	Victor G. McVicker Division of Delivery Systems and Financing

Description: This master contract provides for the design, development, conduct, and evaluation of Medicare institutional/facility-based services demonstration projects. The intent of these demonstration projects is to obtain information in a timely manner for program and policy consideration.

Status: This master contract was awarded in September 1992. This awardee is able to compete for individual delivery orders (DO) for 36 months. The first DO (awarded concurrently with the base contract) is for general management, which includes submitting monthly reports, meeting with the Federal Government on request, and responding to requests for issue papers. The overall 36-month funding amount for the first DO, 500-92-0047DO01, Management Delivery Order, is $38,706. This master contract ended on September 30, 1995.

The individual DO projects awarded under the master contract are described in detail in the following sections of this *Status Report.*

Provider Payment:
- Evaluate Iowa Implementation of APGs, 500-92-0047DO02.

Access and Quality of Care:
- A Proposal to Evaluate Rural Health Clinics, 500-92-0047DO03.
- Evaluation of the Rural Health Clinics, 500-92-0047DO03.

92-077 **Medicare Institutional/ Facility-Based Services Demonstration Projects: Master Contract: University of Minnesota** (Formerly, Medicare Institutional/ Facility-Based Services Demonstration Projects: Master Contracts)

Project No.:	500-92-0048
Period:	September 1992–September 1995
Award:	Contract
Principal Investigator:	Robert L. Kane, M.D.
Awardee:	University of Minnesota School of Public Health Institute for Health Services Research D-351 Mayo Memorial Building 420 Delaware Street, SE., Box 197 Minneapolis, MN 55455-0392
HCFA Project Officer:	Victor G. McVicker Division of Delivery Systems and Financing

Description: This master contract provides for the design, development, conduct, and evaluation of Medicare institutional/facility-based services demonstration projects. The intent of these demonstration projects is to obtain information in a timely manner for program and policy consideration.

Status: This master contract was awarded in September 1992. This awardee is able to compete for individual delivery orders (DO) for 36 months. The first DO (awarded concurrently with the base contract) is for general management, which includes submitting monthly reports, meeting with the Government on request, and responding to requests for issue papers. The overall 36-month funding amount for the first DO, 500-92-0048DO01, Management Delivery Order is $58,391. This master contract ended on September 30, 1995.

Another individual DO project awarded under the master contract is:

- Improving the Discharge Planning Process, 500-92-0048DO02.

93-086 Research Centers: Master Contract: Abt Associates, Inc.

Project No.:	500-93-0029
Period:	September 1993–September 1995
Award:	Contract
Principal Investigator:	William D. Marder, Ph.D.
Awardee:	Abt Associates, Inc. 55 Wheeler Street Cambridge, MA 02138-1168
HCFA Project Officer:	Leslie A. Mangels Financial, Administrative, and Procurement Staff

Description: This master contract provided for the design, development, and conduct of research and demonstration projects. The intent of these projects is to obtain information in a timely manner for program and policy consideration.

Status: This master contract was awarded in September 1993. The first delivery order (DO) (awarded concurrently with the base contract) was for general management, which included submitting monthly reports, meeting with the Federal Government on request, and responding to requests for issue papers. The overall funding amount for this Management DO, 500-93-0029DO01, is $20,261.

The individual DO project awarded under the master contract is described in detail in the following section of this *Status Report*.

Provider Payment:

- Evaluating Methods of Estimating Hospital Efficiency, 500-93-0029DO02.

92-087 Research Centers:Master Contract: Health Economics Research, Inc.

Project No.:	500-92-0020
Period:	August 1992–August 1996
Award:	Contract
Principal Investigator:	Janet B. Mitchell, Ph.D.
Awardee:	Health Economics Research, Inc. 300 Fifth Avenue, 6th Floor Waltham, MA 02154
HCFA Project Officer:	Leslie A. Mangels Financial, Administrative, and Procurement Staff

Description: This master contract provides for the design, development, and conduct of research and demonstration projects. The intent of these projects is to obtain information in a timely manner for program and policy consideration.

Status: This master contract was awarded in August 1992. The first delivery order (DO) (awarded concurrently with the base contract) is for general management, which includes submitting monthly reports, meeting with the Federal Government on request, and responding to requests for issue papers. The overall funding amount for the Management DO, 500-92-0020DO01, is $38,911.

The individual DO projects awarded under the master contract are described in detail in the following sections of this *Status Report*.

Health Care Systems Reform and Financing:

- State Primer on All-Payer Systems for Health Care Services, 500-92-0020DO04.
- Update and Revision of the Continuous Update Diagnostic Cost Group Model, 500-92-0020DO06.
- Issues Related to the Federal Government Drug Payment Policies in the Reformed Health Care Environment, 500-92-0020DO10.

Provider Payment:

- Assessment and Redesign of Medicare Fee Schedule Areas (Localities), 500-92-0020DO09.
- Prospective Per Case Payment for Episodes of Hospital Care, 500-92-0020DO07.
- Unique Physician Identification Number Validation Studies, 500-92-0020DO05.
- Derivation of Relative Values for Practice Expense Using Extant Data, 500-92-0020DO12.
- Second Revision of Medicare Geographic Practice Cost Index, 500-92-0020DO13.
- Understanding Properties of the UPIN for Claims-Based Research, 500-92-0020DO14.

Access and Quality of Care:
- Estimating Mammography Utilization by Elderly Medicare Women for Whom the Health Care Financing Administration Does Not Receive Administrative Claims, 500-92-0020DO11.

Program Statistics:
- Patterns of Utilization and Expenditures for Prescription Drugs in Selected State Medicaid Programs, 500-92-0020DO08.

93-088 **Research Centers: Master Contract: KPMG Peat Marwick** (Formerly, Research Centers: Master Contracts)

Project No.:	500-93-0031
Period:	September 1993–September 1995
Award:	Contract
Principal Investigator:	Kathryn M. Langwell
Awardee:	KPMG Peat Marwick Policy Economics Group 2001 M Street, NW. Washington, D.C. 20036
HCFA Project Officer:	Leslie A. Mangels Financial, Administrative, and Procurement Staff

Description: This master contract provides for the design, development, and conduct of research center projects. The intent of these demonstration projects is to obtain information in a timely manner for program and policy consideration.

Status: This master contract was awarded in September 1993. The first delivery order (DO) (awarded concurrently with the base contract) is for general management, which includes submitting monthly reports, meeting with the Federal Government on request, and responding to requests for issue papers. The overall funding amount for the Management DO, 500-93-0031DO01, is $30,360.

The individual DO project awarded under the master contract is described in detail in the following section of this *Status Report*.

Health Care Systems Reform and Financing:
- Issues Related to the Federal Government Drug Payment Policies in the Reformed Health Care Environment: KPMG Peat Marwick, 500-93-0031DO02.

92-088 **Research Centers: Master Contract: Lewin/VHI, Inc.**

Project No.:	500-92-0021
Period:	August 1992–August 1996
Award:	Contract
Principal Investigator:	Allen Dobson, Ph.D.
Awardee:	Lewin/VHI, Inc. 9300 Lee Highway, Suite 500 Fairfax, VA 22031-1207
HCFA Project Officer:	Leslie A. Mangels Financial, Administrative and Procurement Staff

Description: This master contract provides for the design, development, and conduct of research and demonstration projects. The intent of these projects is to obtain information in a timely manner for program and policy consideration.

Status: This master contract was awarded in August 1992. The first delivery order (DO) (awarded concurrently with the base contract) is for general management, which includes submitting monthly reports, meeting with the Federal Government on request, and responding to requests for issue papers. The overall funding amount for the Management DO, 500-92-0021DO01, is $24,044.

The individual DO projects awarded under the master contract are described in detail in the following sections of this *Status Report*.

Health Care Systems Reform and Financing:
- Developing Methodologies for Assessing the Effectiveness of Medicare Parts A and B Medical Review, 500-92-0021DO03.
- Development and Testing of Risk Adjusters Using Medicare Inpatient and Ambulatory Data, 500-92-0021DO02.
- Development of a Risk-Adjustment System Under Health Reform, 500-92-0021DO05.

Access and Quality of Care:
- Study of the Natural History of End Stage Renal Disease in Persons with Diabetes, 500-92-0021DO04.

94-115 Research Centers: Master Contract: Michigan Public Health Institute

Project No.:	500-94-0064
Period:	September 1994–September 1995
Award:	Contract
Principal Investigator:	William Weissert, Ph.D.
Awardee:	Michigan Public Health Institute 2465 Woodlake Circle, Suite 140 Okemos, MI 48864
HCFA Project Officer:	Leslie A. Mangels Financial, Administrative, and Procurement Staff

Description: This master contract provides for the design, development, and conduct of research center projects. The intent of these demonstration projects is to obtain information in a timely manner for program and policy consideration.

Status: This master contract was awarded in September 1994. This awardee is able to compete for individual delivery orders (DO) until September 1995. The first DO (awarded concurrently with the base contract) is for general management, which includes submitting monthly reports, meeting with the Federal Government on request, and responding to requests for issue papers. The overall funding amount for the first DO, 500-94-0064DO01, is $8,416.

This awardee has not been awarded any additional DOs.

92-090 Research Centers: Master Contract: The RAND Corporation

Project No.:	500-92-0023
Period:	August 1992–June 1996
Award:	Contract
Principal Investigator:	Grace M. Carter, Ph.D.
Awardee:	The RAND Corporation Health Sciences Program 1700 Main Street, P.O. Box 2138 Santa Monica, CA 90407-2138
HCFA Project Officer:	Leslie A. Mangels Financial, Administrative, and Procurement Staff

Description: This master contract provided for the design, development, and conduct of research and demonstration projects. The intent of these projects is to obtain information in a timely manner for program and policy consideration.

Status: This master contract was awarded in August 1992. The first delivery order (DO) (awarded concurrently with the base contract) is for general management, which includes submitting monthly reports, meeting with the Federal Government on request, and responding to requests for issue papers. The overall funding amount for the Management DO, 500-92-0023DO01, is $64,244.

The individual DO projects awarded under the master contract are described in detail in the following sections of this *Status Report.*

Health Care Systems Reform and Financing:
- Development of a Risk Adjustment System Under Health Reform: The RAND Corporation, 500-92-0023DO09.

Provider Payment:
- Derivation of Relative Values for Practice Expense Using Extant Data, 500-92-0023DO10.
- Evaluation of Case Classification Systems and a Design of a Prospective Payment Model for Inpatient Rehabilitation, 500-92-0023DO11.

Access and Quality of Care:
- Design of a Cost-Effectiveness Protocol for the Morbidity and Mortality in Hemodialysis Clinical Trials, 500-92-0023DO07.

Another individual DO project awarded under the master contract is:
- Examination of Alternative Methods for Calculating Relative Values for Practice Expense: The RAND Corporation, 500-92-0023DO06.

92-091 Research Centers: Master Contract: The Urban Institute

Project No.:	500-92-0024
Period:	August 1992–March 1996
Award:	Contract
Principal Investigator:	John Holahan, Ph.D.
Awardee:	The Urban Institute Health Policy Center 2100 M Street, NW. Washington, D.C. 20037
HCFA Project Officer:	Leslie A. Mangels Financial, Administrative, and Procurement Staff

Description: This master contract provides for the design, development, and conduct of research and demonstration projects. The intent of these projects is to obtain information in a timely manner for program and policy consideration.

Status: This master contract was awarded in August 1992. The first delivery order (DO) (awarded concurrently with the base contract) is for general management, which includes submitting monthly reports, meeting with the Government on

request, and responding to requests for issue papers. The overall funding amount for the Management DO, 500-92-0024DO01, is $36,228.

The individual DO projects awarded under the master contract are described in detail in the following sections of this *Status Report*.

Health Care Systems Reform and Financing:
- Assessing the Viability of Developing All-Payer Systems for Health Care Services: the Urban Institute, 500-92-0024DO04.
- Issues Involved in Developing a Standardized Benefit Package, 500-92-0024DO05.
- Options for Federal Funding for State Costs Under Health Care Reforms, 500-92-0024DO06.

Access and Quality of Care:
- Uniform Clinical Data Set Algorithm Refinement Project, 500-92-0024DO07.

92-089 Research Centers: Master Contract: University of Minnesota

Project No.:	500-92-0022
Period:	August 1992–December 1996
Award:	Contract
Principal Investigator:	Jon Christianson, Ph.D.
Awardee:	University of Minnesota Institute for Health Services Research School of Public Health, Box 729 420 Delaware Street, SE. Minneapolis, MN 55455-0392
HCFA Project Officer:	Leslie A. Mangels Financial, Administrative, and Procurement Staff

Description: This master contract provides for the design, development, and conduct of research and demonstration projects. The intent of these projects is to obtain information in a timely manner for program and policy consideration.

Status: This master contract was awarded in August 1992. The first delivery order (DO) (awarded concurrently with the base contract) is for general management, which includes submitting monthly reports, meeting with the Federal Government on request, and responding to requests for issue papers. The overall funding amount for the Management DO, 500-92-0022DO01, is $43,150.

The individual DO projects awarded under the master contract are described in detail in the following sections of this *Status Report*.

Provider Payment:
- Examination of Alternative Methods for Calculating Relative Values for Practice Expense: The University of Minnesota, 500-92-0022DO02.

Access and Quality of Care:
- Assessment of the Impact of Medicaid Drug Rebate Policy on Expenditures, Utilization, and Access, 500-92-0022DO03.
- Multistate Analysis of Utilization, Expenditures, and Access to Care for Persons with Acquired Immunodeficiency Syndrome, 500-92-0022DO04.

94-116 Research Centers: Master Contract: University of Wisconsin-Madison

Project No.:	500-94-0065
Period:	September 1994–September 1995
Award:	Contract
Principal Investigator:	David R. Zimmerman, Ph.D.
Awardee:	University of Wisconsin-Madison Research Administration-Financial 750 University Avenue Madison, WI 53706-1490
HCFA Project Officer:	Leslie A. Mangels Financial, Administrative, and Procurement Staff

Description: This master contract provides for the design, development, and conduct of research center projects. The intent of these demonstration projects is to obtain information in a timely manner for program and policy consideration.

Status: This master contract was awarded in September 1994. The first delivery order (DO) (awarded concurrently with the base contract) is for general management, which includes submitting monthly reports, meeting with the Federal Government on request, and responding to requests for issue papers. The overall funding amount for this Management DO, 500-94-0064DO01, is $10,982.

The individual DO awarded the master contract is described in detail in the following section of the *Status Report*.

Health Care Systems Reform and Financing:
- Assessment of the Impact of Pharmacy Benefits Managers, 500-94-0065DO02.

Task Order Contracts

95-038 Managed Care Research and Demonstration Task Order Contract: Barents Group, LLC

Project No.:	500-95-0046
Period:	September 1995–September 1996
Award:	Contract
Principal Investigator:	Darwin Johnson
Awardee:	Barents Group, LLC 2001 M Street, NW. Washington, D.C. 20036
HCFA Project Officer:	Leslie A. Mangels Financial, Administrative, and Procurement Staff

Description: This task order contract provides for the design, development, and conduct of managed care research and demonstration projects. The intent of these projects is to obtain information in a timely manner for program and policy consideration.

Status: This task order contract was awarded in September 1995. This awardee is able to compete for individual task orders (TO) until September 2000. The first TO (awarded concurrently with the base contract) is for general management, which includes submitting monthly reports, meeting with the Federal Government on request, and responding to requests for issue papers. The overall funding amount for the Management TO, 500-95-0046TO1, is $9,225.

This awardee has not been awarded any additional TOs.

95-040 Managed Care Research and Demonstration Task Order Contract: Health Economics Research

Project No.:	500-95-0048
Period:	September 1995–September 1996
Award:	Contract
Principal Investigator:	Janet B. Mitchell, Ph.D.
Awardee:	Health Economics Research, Inc. 300 Fifth Avenue, 6th Floor Waltham, MA 02154
HCFA Project Officer:	Leslie A. Mangels Financial, Administrative, and Procurement Staff

Description: This task order contract provides for the design, development, and conduct of managed care research and demonstration projects. The intent of these projects is to obtain information in a timely manner for program and policy consideration.

Status: This task order contract was awarded in September 1995. This awardee is able to compete for individual task orders (TO) until September 2000. The first TO (awarded concurrently with the base contract) is for general management, which includes submitting monthly reports, meeting with the Federal Government on request, and responding to requests for issue papers. The overall funding amount for the Management TO, 500-95-0048TO1, is $5,417.

The individual TO projects awarded under this contract are described in detail in the following sections of this *Status Report.*

Access and Quality of Care:
- Access in Managed Care Plans, 500-95-0048TO2.

95-041 Managed Care Research and Demonstration Task Order Contract: Lewin-VHI, Inc.

Project No.:	500-95-0049
Period:	September 1995–September 1996
Award:	Contract
Principal Investigator:	David Stapleton
Awardee:	Lewin-VHI, Inc. 9302 Lee Highway, Suite 500 Fairfax, VA 22031-1214
HCFA Project Officer:	Leslie A. Mangels Financial, Administrative, and Procurement Staff

Description: This task order contract provides for the design, development, and conduct of managed care research and demonstration projects. The intent of these projects is to obtain information in a timely manner for program and policy consideration.

Status: This task order contract was awarded in September 1995. This awardee is able to compete for individual task orders (TO) until September 2000. The first TO (awarded concurrently with the base contract) is for general management, which includes submitting monthly reports,

meeting with the Federal Government on request, and responding to requests for issue papers. The overall funding amount for the Management TO, 500-95-0049TO1, is $5,369.

This awardee has not been awarded any additional TOs.

95-042 Managed Care Research and Demonstration Task Order Contract: Mathematica Policy Research

Project No.:	500-95-0048
Period:	September 1995–September 1996
Award:	Contract
Principal Investigator:	Don F. Lara
Awardee:	Mathematica Policy Research 101 Morgan Lane Plainsboro, NJ 08536
HCFA Project Officer:	Leslie A. Mangels Financial, Administrative, and Procurement Staff

Description: This task order contract provides for the design, development, and conduct of managed care research and demonstration projects. The intent of these projects is to obtain information in a timely manner for program and policy consideration.

Status: This task order contract was awarded in September 1995. This awardee is able to compete for individual task orders (TO) until September 2000. The first TO (awarded concurrently with the base contract) is for general management, which includes submitting monthly reports, meeting with the Federal Government on request, and responding to requests for issue papers. The overall funding amount for the Management TO, 500-95-0047TO1, is $5,592.

The individual TO projects awarded under this task order contract are described in detail in the following sections of this *Status Report*.

Health Care Systems Reform and Financing:
- Evaluation of the HMO Outlier Demonstration, 500-95-0047TO02.

95-043 Managed Care Research and Demonstration Task Order Contract: The MedStat Group

Project No.:	500-95-0050
Period:	September 1995–September 1996
Award:	Contract
Principal Investigator:	Claude A. Bowen
Awardee:	The MedStat Group 4401 Connecticut Avenue, NW. Washington, D.C. 20008
HCFA Project Officer:	Leslie A. Mangels Financial, Administrative, and Procurement Staff

Description: This task order contract provides for the design, development, and conduct of managed care research and demonstration projects. The intent of these projects is to obtain information in a timely manner for program and policy consideration.

Status: This task order contract was awarded in September 1995. This awardee is able to compete for individual task orders (TO) until September 2000. The first TO (awarded concurrently with the base contract) is for general management, which includes submitting monthly reports, meeting with the Federal Government on request, and responding to requests for issue papers. The overall funding amount for the Management TO, 500-95-0050TO1, is $9,149.

This awardee has not been awarded any additional TOs.

95-044 Managed Care Research and Demonstration Task Order Contract: The RAND Corporation

Project No.:	500-95-0051
Period:	September 1995–September 1996
Award:	Contract
Principal Investigator:	Richard L. Wright
Awardee:	The RAND Corporation 1700 Main Street Santa Monica, CA 90407-2138
HCFA Project Officer:	Leslie A. Mangels Financial, Administrative, and Procurement Staff

Description: This task order contract provides for the design, development, and conduct of managed care research and demonstration projects. The intent of these projects is to obtain information in a timely manner for program and policy consideration.

Status: This task order contract was awarded in September 1995. This awardee is able to compete for individual task orders (TOs) until September 2000. The first TO (awarded concurrently with the base contract) is for general management, which includes submitting monthly reports,

meeting with the Federal Government on request, and responding to requests for issue papers. The overall funding amount for the management TO, 500-95-0054TO1, is $6,441.

This awardee has not been awarded any additional TOs.

95-045 Managed Care Research and Demonstration Task Order Contract: University of Minnesota

Project No.:	500-95-0053
Period:	September 1995–September 1996
Award:	Contract
Principal Investigator:	Richard L. Wright
Awardee:	University of Minnesota 420 Delaware Street, SE. Minneapolis, MN 55455-0392
HCFA Project Officer:	Leslie A. Mangels Financial, Administrative and Procurement Staff

Description: This task order contract provides for the design, development, and conduct of managed care research and demonstration projects. The intent of these projects is to obtain information in a timely manner for program and policy consideration.

Status: This task order contract was awarded in September 1995. This awardee is able to compete for individual task orders (TOs) until September 2000. The first TO (awarded concurrently with the base contract) is for general management, which includes submitting monthly reports, meeting with the Federal Government on request, and responding to requests for issue papers. The overall funding amount for the management TO, 500-95-0053TO1, is $6,806.

This awardee has not been awarded any additional TOs.

95-034 Research and Demonstration Task Order Contract

Project No.:	500-95-0059
Period:	September 1995–September 1996
Award:	Contract
Principal Investigator:	Allen Dobson
Awardee:	Lewin-VHI 9302 Lee Highway, Suite 500 Fairfax, VA 22031-1214
HCFA Project Officer:	Leslie A. Mangels Financial, Administrative, and Procurement Staff

Description: This task order contract provides for the design, development, and conduct of research and demonstration projects. The intent of these projects is to obtain information in a timely manner for program and policy consideration.

Status: This task order contract was awarded in September 1995. This awardee is able to compete for individual task orders (TO) until September 2000. The first TO (awarded concurrently with the base contract) is for general management, which includes submitting monthly reports, meeting with the Federal Government on request, and responding to requests for issue papers. The overall funding amount for the Management TO, 500-95-0059TO01, is $4,915.

This awardee has not been awarded any additional TOs.

95-030 Research and Demonstration Task Order Contract: Abt Associates, Inc.

Project No.:	500-95-0062
Period:	September 1995–September 1996
Award:	Contract
Principal Investigator:	David Kidder
Awardee:	Abt Associates, Inc. 55 Wheeler Street Cambridge, MA 02138
HCFA Project Officer:	Leslie A. Mangels Financial, Administrative, and Procurement Staff

Description: This task order contract provides for the design, development, and conduct of research and demonstration projects. The intent of these projects is to obtain information in a timely manner for program and policy consideration.

Status: This task order contract was awarded in September 1995. This awardee is able to compete for individual task orders (TO) until September 2000. The first TO (awarded concurrently with the base contract) is for general management, which includes submitting monthly reports, meeting with the Federal Government on request, and responding to requests for issue papers. The overall funding amount for the Management TO, 500-95-0062TO01, is $5,356.

This awardee has not been awarded any additional TOs.

95-031 Research and Demonstration Task Order Contract: Barents Group, LLC

Project No.:	500-95-0057
Period:	September 1995–September 1996
Award:	Contract
Principal Investigator:	Darwin Johnson
Awardee:	Barents Group, LLC 2001 M Street, NW. Washington, D.C. 20036
HCFA Project Officer:	Leslie A. Mangels Financial, Administrative, and Procurement Staff

Description: This task order contract provides for the design, development, and conduct of research and demonstration projects. The intent of these projects is to obtain information in a timely manner for program and policy consideration.

Status: This task order contract was awarded in September 1995. This awardee is able to compete for individual task orders (TO) until September 2000. The first TO (awarded concurrently with the base contract) is for general management, which includes submitting monthly reports, meeting with the Federal Government on request, and responding to requests for issue papers. The overall funding amount for the Management TO, 500-95-0057TO01, is $9,225.

This awardee has not been awarded any additional TOs.

95-032 Research and Demonstration Task Order Contract: Brandeis University

Project No.:	500-95-0060
Period:	September 1995–September 1996
Award:	Contract
Principal Investigator:	Joel M. Cohen
Awardee:	Brandeis University Institute for Health Policy 415 South Street Waltham, MA 02254-9110
HCFA Project Officer:	Leslie A. Mangels Financial, Administrative, and Procurement Staff

Description: This task order contract provides for the design, development, and conduct of research and demonstration projects. The intent of these projects is to obtain information in a timely manner for program and policy consideration.

Status: This task order contract was awarded in September 1995. This awardee is able to compete for individual task orders (TO) until September 2000. The first TO (awarded concurrently with the base contract) is for general management, which includes submitting monthly reports, meeting with the Federal Government on request, and responding to requests for issue papers. The overall funding amount for the Management TO, 500-95-0060TO01, is $6,429.

This awardee has not been awarded any additional TOs.

95-039 Managed Care Research and Demonstration Task Order Contract: Brandeis University

Project No.:	500-95-0052
Period:	September 1995–September 1996
Award:	Contract
Principal Investigator:	Joel M. Cohen
Awardee:	Brandeis University Institute for Health Policy 415 South Street Waltham, MA 02254-9110
HCFA Project Officer:	Leslie A. Mangels Financial, Administrative, and Procurement Staff

Description: This task order contract provides for the design, development, and conduct of managed care research and demonstration projects. The intent of these projects is to obtain information in a timely manner for program and policy consideration.

Status: This task order contract was awarded in September 1995. This awardee is able to compete for individual task orders (TO) until September 2000. The first TO (awarded concurrently with the base contract) is for general management, which includes submitting monthly reports, meeting with the Federal Government on request, and responding to requests for issue papers. The overall funding amount for the Management TO, 500-95-0052TO1, is $5,661.

This awardee has not been awarded any additional TOs.

95-033 Research and Demonstration Task Order Contract: Health Economics Research

Project No.:	500-95-0058
Period:	September 1995–September 1996
Award:	Contract

Principal Investigator:	Janet B. Mitchell
Awardee:	Health Economics Research, Inc. 300 Fifth Avenue, 6th Floor Waltham, MA 02154
HCFA Project Officer:	Leslie A. Mangels Financial, Administrative, and Procurement Staff

Description: This task order contract provides for the design, development, and conduct of research and demonstration projects. The intent of these projects is to obtain information in a timely manner for program and policy consideration.

Status: This task order contract was awarded in September 1995. This awardee is able to compete for individual task orders (TO) until September 2000. The first TO (awarded concurrently with the base contract) is for general management, which includes submitting monthly reports, meeting with the Federal Government on request, and responding to requests for issue papers. The overall funding amount for the Management TO, 500-95-0058TO01, is $6,090.

This awardee has not been awarded any additional TOs.

95-035 Research and Demonstration Task Order Contract: The RAND Corporation

Project No.:	500-95-0056
Period:	September 1995–September 1996
Award:	Contract
Principal Investigator:	Richard L. Wright
Awardee:	The RAND Corporation 1700 Main Street P.O. Box 2138 Santa Monica, CA 90407-2138
HCFA Project Officer:	Leslie A. Mangels Financial, Administrative, and Procurement Staff

Description: This task order contract provides for the design, development, and conduct of research and demonstration projects. The intent of these projects is to obtain information in a timely manner for program and policy consideration.

Status: This task order contract was awarded in September 1995. This awardee is able to compete for individual task orders (TO) until September 2000. The first TO (awarded concurrently with the base contract) is for general management, which includes submitting monthly reports, meeting with the Federal Government on request, and responding to requests for issue papers. The overall funding amount for the Management TO, 500-95-0056TO01, is $6,777.

Another individual TO project awarded under this task order contract is:

- Development of a Comprehensive Monitoring and Evaluation Initiative for HCFA Programs, 500-95-0056TO02.

95-036 Research and Demonstration Task Order Contract: University of Wisconsin

Project No.:	500-95-0061
Period:	September 1995–September 1996
Award:	Contract
Principal Investigator:	Robert W. Erickson
Awardee:	University of Wisconsin 750 University Avenue Madison, WI 53706-1490
HCFA Project Officer:	Leslie A. Mangels Financial, Administrative, and Procurement Staff

Description: This task order contract provides for the design, development, and conduct of research and demonstration projects. The intent of these projects is to obtain information in a timely manner for program and policy consideration.

Status: This task order contract was awarded in September 1995. This awardee is able to compete for individual task orders (TO) until September 2000. The first TO (awarded concurrently with the base contract) is for general management, which includes submitting monthly reports, meeting with the Federal Government on request, and responding to requests for issue papers. The overall funding amount for the Management TO, 500-95-0061TO01, is $6,428.

This awardee has not been awarded any additional TOs.

95-037 Research and Demonstration Task Order Contract: The Urban Institute

Project No.:	500-95-0055
Period:	September 1995–September 1996
Award:	Contract

Principal Investigator:	Andrew Orlin
Awardee:	The Urban Institute 2100 M Street, NW. Washington, D.C. 20037
HCFA Project Officer:	Leslie A. Mangels Financial, Administrative, and Procurement Staff

Description: This task order contract provides for the design, development, and conduct of research and demonstration projects. The intent of these projects is to obtain information in a timely manner for program and policy consideration.

Status: This task order contract was awarded in September 1995. This awardee is able to compete for individual task orders (TO) until September 2000. The first TO (awarded concurrently with the base contract) is for general management, which includes submitting monthly reports, meeting with the Federal Government on request, and responding to requests for issue papers. The overall funding amount for the Management TO, 500-95-0055TO1, is $6,428.

Another individual TO project awarded under this task order contract is:

- Evaluation of the Municipal Health Service Program (MHSP) Demonstration, 500-95-0055TO02.

95-071 **Voice-Assisted Data Entry and Management for Home Health Agencies**

Project No.:	97-P-08120/6-01
Period:	June 1995–June 1996
Funding:	$ 45,477
Award:	Grant
Principal Investigator:	Ken A. Barnett
Awardee:	Technology International, Inc. 429 West Airline Highway, Suite S LaPlace, LA 70068
HCFA Project Officer:	Leslie A. Mangels Financial, Administrative, and Procurement Staff
Mandate:	Small Business Innovation Development Act of 1982 (Public Law 97-219, as amended by Public Law 99-443)

Description: This project will design a prototype system (Ptolemy) as a first step in developing a computer-based patient record. The purpose of this phase I project is to (1) extend the prototype into a functional, collaborative reporting system for echocardiography and upper gastrointestinal endoscopy services and (2) test the degree to which it meets requirements of the system.

Status: Phase I (development) is currently being performed.

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Project Officers and Project Directors

Name	Area Code (410) and Telephone Number	Location
Adamo, Alisa	786-6618	C-3-18-25
Babish, Daniel J.	786-6607	C-3-12-26
Bae, Jay	786-6591	C-3-17-05
Baier, Michael J.	786-6664	C-3-24-03
Bandzwolek, Joanna K.	786-6643	C-3-11-26
Benedict, Beth M.	786-7724	C-3-25-24
Boben, Paul J.	786-6629	C-3-20-07
Boulmetris, Maria	786-0552	C-3-18-26
Bragg, Richard	786-7250	C-3-21-06
Brown, Samuel L.	786-6667	C-3-23-05
Buczko, William	786-6593	C-3-16-25
Cagey, Clark M.	786-7711	C-3-18-26
Chiang, Yen-Pin	786-6682	C-3-15-06
Clark, William D.	786-1484	C-3-22-04
Cornelius, Elizabeth S.	786-6655	C-3-16-13
Cotterill, Philip G.	786-6598	C-3-15-27
Cramer, Joseph M.	786-6676	C-3-17-04
Damrosch, William L.	786-6678	C-3-16-23
Davenport, Marsha G.	786-6693	C-3-21-25
Davis, Feather Ann	786-6590	C-3-22-26
Deacon, Ronald W.	786-6622	C-3-14-01
DeCaro, Teresa L.	786-6604	C-3-17-06
Dutton, Benson L.	786-6603	C-3-17-24
Duzor, Spike	786-1794	C-3-12-28
Edington, Bonnie M.	786-6617	C-3-20-14
Eggers, Paul W.	786-6691	C-3-24-08
England, William L.	786-0542	C-3-23-23
Fitterman, Leslye	786-7596	C-3-24-13
Freedman, Alvin L.	786-6597	C-3-21-01
Fried, Sherrie L.	786-6619	C-3-19-17
Friedman, Maria A.	786-9915	C-3-10-27
Gondek, Kathleen	786-7765	C-3-14-05
Goody, Brigid	786-6640	C-3-14-04
Greenberg, Barbara	786-6654	C-3-22-25
Greenwald, Leslie M.	786-6502	C-3-14-03
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Hackerman, Carl S.	786-6644	C-3-11-18
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Hatten, Rose M.	786-6630	C-3-19-18
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Henesch, Michael	786-6685	C-3-17-25
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Ingber, Melvin J.	786-1913	C-3-15-26
Johnson, Bruce	786-0615	C-3-18-26

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Kendix, Michael	786-6631	C-3-23-24
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Levy, Jesse M.	786-6600	C-3-16-06
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Lubitz, James D.	786-6696	C-3-21-17
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Mangels, Leslie A.	786-0494	C-3-12-05
Mason, Cynthia K.	786-6680	C-3-15-24
Mauser, Elizabeth	786-6665	C-3-21-16
Mazumdar, Siddhartha	786-6673	C-3-16-24
McNiff Hulbert, Melissa	786-8494	C-3-22-15
McVicker, Victor G.	786-6681	C-3-14-14
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Nagy, Phyllis A.	786-6646	C-3-21-15
Nugent, Dennis M.	786-6663	C-3-21-14
O'Brien, Ellen	786-6662	C-3-22-05
Peden, Edgar A.	786-6594	C-3-16-15
Peterson, Joan	786-0621	C-3-21-04
Pine, Penelope L.	786-7718	C-3-24-24
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Rhodes, Rhonda	786-6614	C-3-18-06
Riley, Gerald F.	786-6699	C-3-22-23
Rimes, Carolyn	786-6620	C-3-22-16
Rotwein, Suzanne	786-6621	C-3-24-14
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Sherwood, J. Donald	786-6651	C-3-18-24
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Sobaski, William J.	786-6588	C-3-16-07
Teichman, Lori E.	786-6684	C-3-26-05
Terrell, Sherry A.	786-6601	C-3-18-03
Theis, Thomas	786-6654	C-3-22-25
Thoumaian, Armen H.	786-6672	C-3-14-25
Trontell, Anne A.	786-4709	C-3-21-26
Tudor, Cynthia G.	786-6499	C-3-22-03
Van Hoven, Deborah C.	786-6625	C-3-19-28
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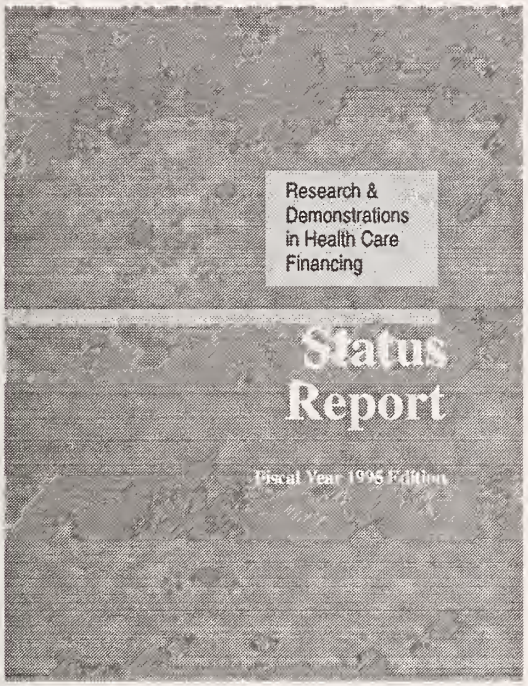

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